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THE NEW PRESIDENT OF THE N.O.P.H.N.

AMELIA GRANT

Elected by the largest vote in the history of the National Organization for Public Health Nursing, Amelia Grant assumed the responsibilities of the presidency on Friday morning, April 27, 1934. In the time-worn phrase of the lecture platform—"Miss Grant needs no introduction to our readers." She is and has been for six years Director of the Bureau of Nursing of the Department of Health in New York City. We are confident that any one who can settle the nursing problems of a health department in a city of several million souls will find the problems of twenty thousand public health nurses in the United States mere child's play!

Miss Grant is a graduate of Faxton Hospital School of Nursing in Utica, N. Y., and has taken postgraduate work at Simmons College and Teachers College, from which latter institution she holds the M.A. degree. She has been a supervisor in the Henry Street Visiting Nurse Service, instructor in nursing education, Teachers College, assistant professor in the Yale University School of Nursing, and assistant director in the Bellevue-Yorkville Health Demonstration, New York City.

The Board of Directors of the N.O.P.H.N., our members, the readers of this magazine, and public health nurses everywhere rejoice in this honor which has come to Miss Grant and welcome her warmly to her new office.



The Biennial Convention

THROUGH THE EYES OF A LAYMAN

By AGNES NICHOLSON STOKES

Chairman, Education and Publicity Committee, Visiting Nurse Association, Moorestown, N. J.

WASHINGTON'S great new buildings, cherry blossoms, and the D.A.R. folding its tents and packing its banners in retreat before the oncoming hordes of nurses, these were the first impressions of a board member on her arrival at the Biennial Convention. Then loomed the shabby convention hall in whose lobby pressing multitudes bent on registering, were held in check by good-natured policemen. In the auditorium itself, conflicting echoes from loud speakers waged war on the ears of the eager swarms, who finally, program and notebook in hand, settled back to the realization that they were in Washington, that they were attending an important convention, and that what they gathered there was essential to them as individuals and as nurses, if they were to wield a well-directed oar through the rip tides of present-day life. The minor inconveniences of crowds, widely scattered meeting places and scarce hotel accommodations were forgotten in the enjoyment of the gracious hospitality of the Washington hostesses of the Instructive Visiting Nurse Society and the devouring of the extensive fare set before the delegates by the program committees of the three national nursing organizations.

Over all consideration of specific nursing and organization problems hovered the cloud of a social order in flux. Inevitable mutations in the economic set-up, the shaking of social and political philosophies, uncertainties, questions, doubts, and theories were lovingly examined or critically scrutinized. What will be the future of the cause of public health? As Mr. Eduard C. Lindeman brought out, general public health is nothing but a dream while sixty per cent of the population are inadequately housed and twenty per cent indecently so. A more equitable

distribution of income may be one of the ways, perhaps, to remedy this and many other problems, in order to make a reality of the vision of children well born and adults with keen eyes and straight backs. General health protection must be woven into the fabric of the new social order, and our civilization will be measured by the speed with which this is accomplished.

Out of the swamp of uncertainty and discouragement in the social thinking of the last five years have emerged two streams of growing strength and increasing volume. First, the failure of private resources in some places has led agencies to rely more and more on official aid, and second, welfare organizations have learned to work together, often to combine, in the realization that their problems are interrelated and the solutions interdependent. As private funds slowed down and often ceased to trickle, social workers, with the vision before their eyes of a desperate need, began to besiege government bureaus, municipal, state, and federal. This has been increasingly the case, while public agencies themselves have grown in importance and state and municipal nursing services have enlarged their borders. Private and public health organizations and welfare agencies in many communities have learned their blood brotherhood. Many have under consideration further mergers that will result in a more efficient service given with less duplication, loss of time, and expenditure of funds. The N.O.P.H.N. has kept its ear to the ground and has worked more closely than ever before with the U. S. Public Health Service, the F.E.R.A., and the Federal Children's Bureau, setting standards, advising, discussing, so that the streams may flow down peaceful and fruitful valleys.

That nurses may become effective

instruments for building a new world, the emphasis of the Washington meetings was on education, more education and yet again more. Only four per cent of nursing schools require of their applicants superior standing in high school. Student nurses in the past have been exploited in many places instead of educated by their hospitals and only a relatively small number of public health nurses have had post-graduate courses or sufficient time in the practice field to fit them for their specialty. Entrance requirements must be more rigid, training schools fewer, better and preferably attached to a university, and nurses must pay for their education as do doctors. Above all they must be trained to regard themselves as citizens with their profession as the means for carrying out the responsibility of citizenship.

If nurses were invited to look at themselves, board members were also set before the mirror. It is no time for boards to sit in water-tight compartments carrying on traditional activities while the tides of life swirl by, carving new channels and heaping new sandbars. Miss Evelyn K. Davis brought out in the report of her five years of work as Secretary for the Board Members' Section of the N.O.P.H.N., that board members have become more board conscious, more public health conscious, and more community conscious, but their frail wagons often are hitched to stars which are still very distant. Board thinking, grounded on the rock of good judgment and solid practice, must vibrate more to new ideas. Nurses can do nothing in the crisis unless supported by an aroused and intelligent citizenry. Lay members have the opportunity of sharing as co-workers and the vanguard in the modern health program. Great edifices are built of individual bricks skillfully laid, and board members have a responsibility to raise the walls of a new national life when "the health of each will become the concern of all."

The following specific ideas were presented for the consideration of the 125 lay members. Suggested changes in board organization included the addition of more men—lawyers, bankers, and

other business men, and a wide community representation from churches, parent-teacher associations, schools and boards of health. Rotation of officers and members was urged, with a junior auxiliary or volunteer service as a strength to and a feeder for the board. It is a sign of great weakness when an organization can muster only one person of presidential caliber, and these younger groups coming in can solve the difficulty perhaps for a faithful officer who would be glad to abdicate.

An executive body constituted as above, is better able to know what other community organizations are doing and to work more understandingly with them in a common cause. An important part of this mutual effort is the securing of workable and progressive laws in the field of public health and social welfare. It is squarely the responsibility of the lay group to keep alert to pending legislation, municipal, state, and federal. Medical, educational, housing, and labor laws, as well as problems in budget-making and taxation, all come crashing through into the chosen field of their labors. Boards must be alert to support, to reject, and to fight when necessary.

This Biennial Convention of the A.N.A., N.L.N.E., and N.O.P.H.N., which stand up bravely alongside of the N.R.A., F.E.R.A., and the rest of the alphabetical bodies already present in this teeming city of Washington, has pointed the way of emergence from present chaos. However, as Miss Annie W. Goodrich of the Yale School of Nursing said, "The value of knowledge is not in the possession of it." The Convention is effective only in so far as the nurses and board members have carried away, packed in their bags, a few sticks of dynamite to place under their own particular administrative and community stumps at home. Each particular question wisely settled to the satisfaction of all, each good bill which gains support, each honest and able councilman or legislator who wins his seat through the struggle of socially minded citizens, is just one more brick laid in the wall of an enduring and beautiful national house.

The Biennial Convention

THROUGH THE EYES OF A NURSE

By AGNES J. MARTIN, R.N.

Director, Bureau of Nursing, Department of Health, Syracuse, N. Y.

WASHINGTON furnished a suitable setting for the general theme of this convention—the changing order and the nursing profession. From the capital city have come many of the plans which have shaped our present social and economic program. Dr. Farrand in his foreword to the *Survey of Public Health Nursing** indicates the place of public health nursing in relation to these programs when he says: "The day is past when public health can be treated as a problem independent of economic, social, and educational conditions and if that be true of the public health problem in general it is doubly true of any of its specialized aspects."

At the Convention, it was evident that every phase of nursing is being influenced by these social and economic conditions. These conditions and the changes they have effected in education, legislation, social service, the position of women in industry and health protection were discussed by leaders capable of speaking with authority. The Program Committee did a fine job. The early joint session each morning dealt with a subject of equal interest to all fields of nursing, while the remainder of the day was given to each of the three organizations for their specific problems. The evening sessions were devoted to the social and economic aspects of community welfare. Mrs. Roosevelt took time from her busy life to address the convention on "What Does the Public Expect from Nursing?" making a strong plea for greater development of nursery schools and for nurses who can teach the public to maintain health.

Senator Copeland speaking on health aspects of social legislation drew from the Dillinger case the failure of home, church, and school to influence social

conduct. He quoted the startling figure that twenty-five cents out of every dollar goes to pay for crime.

Several of the speakers mentioned the responsibility of the nurse as a citizen. She must become articulate in community affairs if she is to exercise the leadership for which education and experience have prepared her. One speaker even went so far as to say we were the only professional group that did not have to revise our program to fit the New Deal.

Again and again, it was pointed out that the depression had not only increased the need for public health nursing, but had affected the means of meeting the needs. In some places, there has been greater assumption of health services by official groups; in other communities amalgamation of services has developed; in still others an analysis and evaluation of services have been conducted to determine how essential they are in the whole community program.

The Board and Committee Members Section devoted a session to the use of the well-prepared volunteer in a public health nursing organization, while another session indicated the methods and results in amalgamating fifty-seven organizations into twenty.

The findings and recommendations of the "Survey of Public Health Nursing"** should serve as a basis for staff education programs for the next two years and should prove of great value in appraising present services and analyzing objectives.

No matter at what hour one arrived at a meeting—even at the A.N.A. House of Delegates, scheduled to meet at 8 A.M.—you found many ahead of you. It was most interesting to see this goodly

*The Commonwealth Fund, 41 East 57th Street, New York, N. Y.

**See page 329.

number comfortably seated, reading their newspapers, chatting with friends or arranging the day's program. This last item seems to be one, however, which many nurses (perhaps only those attending their first convention) have never learned to do, for one frequently heard laments of having missed some particular feature because of the wealth of choice in the program.

It was very difficult to hear any floor discussion in the auditorium—and in many of the other meeting places. Naturally meetings must be held in buildings accessible to street car lines and taxi service and with the noise of building construction and street repairs added to these it takes a more powerful voice than most nurses possess to rise above such confusion. We noted, also, that nurses showed little consideration for either the speakers or their fellow listeners. They came and went in midst of papers, changed seats, saved seats through half the meetings, and generally displayed a sad lack of convention manners.

If you did not visit the Folger Library on this visit, go back. It is one of the most stately buildings in Washington, with rare Shakespearian inscriptions under the cornice and a gently cascading fountain on the front terrace. Incidentally, this fountain faces the capitol and bears the inscription, "What Fools These Mortals Be"! The building contains valuable editions open only to advanced Shakespearian students, and an extensive museum collection that may be appreciated by you and me. At one end is a small replica of the London Garrick Theater where Shakespearian rôles were first produced.

Still another happy memory will be the all too hasty visit to the Corcoran Art Gallery. The first floor contains replicas of many of the finest pieces of statuary found in the European galleries, a complete Louis XVI salon, exquisite oriental rugs and Gobelin tapestries, while the second floor was given over largely to the national exhibit of Civil Works artists. Many of these were exceedingly interesting, particularly the one of a young workman which

the paper stated the President and Mrs. Roosevelt had purchased, with some thirty others. The portrait "Maternity" painted by Gari Melchers was particularly appealing to nurses.

In the Jane A. Delano Memorial the nurses of the country have contributed a dignified and lasting monument to the 296 nurses that lost their lives in the World War. The imposing bronze figure stands in the beautiful garden between the National and District of Columbia Red Cross buildings—a most fitting place, as it was the scene of Miss Delano's activities.

The social functions centered around breakfasts, luncheons, teas, and dinners—and it took a social secretary to keep track of the schedule! Frequently, the number presenting themselves far surpassed the number of reservations made, much to the inconvenience of the committee in charge of arrangements. The exhibits were unique in interest and individuality. One would almost question the effect of the depression on these particular firms, so generous were the number and size of the sample souvenirs distributed. Even the weather responded to a changing order—varying from a humid high of 81 degrees on Tuesday, culminating in a heavy shower, to a frosty 36 on Friday, with frequent showers, but with a generous addition of sunshine on other days.

Every nurse privileged to attend the Washington Biennial will continue to have a deepening appreciation of the courteous hospitality of our hostess states, as she returns to her home, and has time to evaluate this unusual experience. The press was exceedingly generous, not only in space allotted, but in the prominence given to many of the addresses, including even editorial comment.

In closing, I should like to repeat Mrs. Whitman Cross's advice that if there were things we did not like about Washington as a convention city, we should not tell Washingtonians about it, but go home and tell our representatives in Congress. This admonition fits many situations in life—constructive criticism belongs to the group with authority to do something about it.

Meeting the New Situations*

BY SOPHIE C. NELSON, R.N.

President, National Organization for Public Health Nursing

TO those whose minds can penetrate beyond cherished phrases to the actualities of life, it is clear that social institutions do change and, in fact, are changing before our very eyes. What is more, these changes, which are causing us today to re-examine our situation with a view to setting our house in order, are veritably so far-reaching that one hesitates to assess them.

We have reached the stage in mental development when we are wholly certain of very little, but of one thing we can be sure: that as society progresses there is likely to be a leveling of wealth. There will probably be less enormous wealth in the hands of a few individuals, and we can only hope that more of the country's income will find its way to those who are now too poor to pay for social services.

More and more taxes are being placed on incomes, estates, and corporations. At the same time, more money is finding its way into the public coffers for the support and maintenance of the accepted social services that have stood the test of time, like public health nursing. As more public responsibility is taken for these services (and the trend seems to be definitely in that direction), and as less money becomes available through the philanthropically-minded well-to-do and the great foundations, the whole complexion of our situation in public health nursing is changed.

An inevitable result of the transference of social services from private to public auspices will be that a larger proportion of the population must, of necessity, be reached, for it will no longer be possible to give intensive nursing care to only a limited group. All must be served. This means that we must make our available services

more productive, and we must use our brains and our brawn to that end.

In the past, public health nursing has paid particular attention to those techniques which tend towards the cure of disease. Bedside care was the oldest of the services and has been exactly what its name implies. If, however, the public health nursing group has kept abreast of the changes in the knowledge of scientific care of the sick, the prevention of disease, and the hygiene of the individual, and if our instruction in the past twenty years has meant anything to society, it would be safe to say that in the future we shall emphasize nursing more in relation to what we *know* as well as in relation to what we *do*.

The success of our performance is likely to be measured not by the nursing treatments given, but by what we teach in relation to the present knowledge of the prevention of disease and defects, the adaptation of the human being to his environment, and the inculcation of the principles of personal hygiene which influence his well-being. So instead of concentrating on bedside care, the nurse of the future, if she is to keep abreast of the social currents in which she finds herself, will be concerned chiefly with teaching the patient to care for himself.

The changes in emphasis, both in relation to our conception of what the nurse contributes and in relation to the method or mechanism by which we operate, are likely to become the problems to which nursing must turn itself in the very near future. The first consideration in relation to this change means that we must assume the attitude of students toward those factors which bear upon human health. We must analyze comprehensively the people's health and social needs. This means that we must become better nurses in

*Presented at the Joint Opening Session of the Biennial Convention of the three national nursing organizations, Monday evening, April 23, 1934.

order that the people may be better served. More than that, it means that we must develop some machinery for broad fact-finding and research, indispensable to progress in the new directions that social services are proceeding. It means that we must enter into a co-operative effort with all other agencies and with all kinds of people—thinking in terms of the health of the community—and that we must evidence a very definite desire to study with others to seek a common solution to the various problems in public welfare.

A mere increase in knowledge is not sufficient to safeguard health and prevent disease. The knowledge must be understood, accepted, and practiced by the people, and we must set in motion machinery that makes this possible. If we accept the fact that there will be a greater public support for social services including nursing, people must be induced to want these services. Somehow they must learn to appreciate the social value of the services we can render, and to insist upon the maintenance of the high standards of nursing care which must survive the transition from private to public administration. Likewise, people generally must accept the assumption that nurses are as properly agents of the state as are, for example, school teachers. This is a large order to place upon us who are trained to act and serve, not to propagandize. We must face this situation squarely and with understanding, for there are many unmistakable signs of what will happen if we shirk this responsibility.

We cannot carry out any plan, however well conceived, unless we mobilize intelligent public opinion behind it. Public interest and support must be earned. When cruel economies have been forced upon municipalities, those services have suffered most that have been least appreciated. It is safe to say that the majority of municipal services in which the staffs have been cut to the point of utter inefficiency are in general those whose leaders have not known how to impress upon the public the value of the services rendered.

More and more there will be a trend, I am sure, in what might be called a

co-operative means of molding public opinion; that is, a machinery for collective thought representing all social interests; in other words, a council of the whole. We shall probably see the rise of many more councils of nurses in conjunction with public health councils and councils of social agencies.

Numerous studies have indicated that although we seem to have an over-supply of nursing and medical services in some instances, yet our distribution is so poor that certain people still go uncared for and some types of services are not available in many places. So, we are not in a position to say that we have medical and health services available to all of the people. Although some service is given through tax-supported agencies and some service is made possible through the philanthropically-minded well-to-do, the payment for services and the availability are still out of the question for certain types of people. We shall probably, in the new order of things, see some community plan created so that the individual may, through some machinery, be able to get the major health services necessary to him.

There will probably be a trend away from free lance nursing to some community plan which may well be an extension of the existing community agencies—the public health nursing organizations, the so-called hourly nursing services, and the registries. The development of these agencies must be such that it will provide all the necessary types of services needed by all the people of the community. This complete nursing service may be supported by interested citizens, the public treasury, or by some plan of insurance, or pre-payment. Perhaps a combination of two, or all three, may contribute to the support of the program. But whatever the eventual plan of support, its consummation means co-operative thinking with all kinds of people, seeking a common solution to the various problems entering into a co-operative endeavor, both for the analysis and study of the people's needs and the setting up of a machinery to help meet those needs.

Given the state of mind, that is, the

desire for coöperation, the medium of expression, such as a council, and the facts necessary, the problem will always remain of securing the adoption of these plans and the joint action for carrying the load.

Most progress and most facts which have been put to the comprehensive use of society have been the result of tedious toil and imaginative insight. There is no reason to suppose that these same things cannot happen in nursing. The great pioneers in all the social fields have studied the facts of nature; they worked upon an hypothesis; they wanted to achieve a result. Sometimes the hypothesis was wrong and they had to begin again; sometimes the hypothesis proved true and a new law of nature was revealed, and this new law was put to the service of society. From time to time, we shall have to build a new hypothesis of public health to meet new situations. We must hold ourselves ready to start in the new directions.

These then are the steps we must harmonize into an effective advance:

The leveling of wealth going on before our very eyes means less private support for public health services.

We may anticipate increased publicly or tax-supported health activities, and when this contingency develops we must be prepared to put our shoulders to the wheel to see that services are well given, and we must be prepared individually to give to the people through those services the benefit of what we know as well as what we do.

If the public treasury is to accept this new burden, people generally must be taken into our confidence, and we must be prepared to lead the way (in a coöperative manner with the citizens of the country) in evolving a machinery in nursing which will make it possible to supply all the needed types and kinds of nursing service to the people. Our success will be the test of our profession.

THE SAUNDERS MEMORIAL AWARD



Annabella McCrae

The Walter Burns Saunders Memorial Medal given to the nurse who "has made to the profession or to the public some outstanding contribution either in personal service or in the discovery of some nursing technique that may be to the advantage of the patient and of the profession" was presented to Annabella McCrae at the joint opening session of the Biennial Convention. The award was made by Dr. N. W. Faxon, Director, Strong Memorial Hospital, Rochester, N. Y., and President of the American Hospital Association. Miss McCrae has been a teacher of nurses for thirty-nine years, the later years being spent at the Massachusetts General Hospital. She has published "Procedures in Nursing" and as Dr. Faxon so aptly said, has had "a determined spirit, sustaining high ideals of conduct, service, achievement throughout many years; a great teacher of nurses." The hundreds of nurses who have had the great privilege of studying under Miss McCrae will rejoice in this professional honor which she so richly deserves.

The Challenge of Today *

BY C.-E. A. WINSLOW, Dr.P.H.

Professor of Public Health, Yale School of Medicine.

SOME 15,000 years ago our ancestors lived in caves along the river terraces of Western Europe. They hunted the bison and the mammoth and drew pictures of them on the walls of their caverns. They fought the bear and the hyena and came into conflict with each other over the possession of desirable dwelling places and favorable hunting grounds. At that time, and for long ages thereafter, the family or the tribe or the people blessed with an aggressive leader, a bold and resourceful fighter, considered itself fortunate. It mattered little if he took the lion's share for himself. There was at least some surplus of the hunt or of the spoils of war left over for his humbler associates. For centuries the conception of a type of leadership which was essentially mastership dominated the social order. In Feudalism it developed its highest ideals in the form of a spiritual compulsion upon the lord to protect and care for his feudatory vassal; but he alone was the judge of the extent of his own responsibilities.

Three forces at least, and no doubt many more, contributed to the development of a second and very different conception of society—the ideal of democracy as opposed to the ideal of autocracy. The emphasis of Christianity certainly played its part for it is chiefly among nations influenced by its tenets that the theory of democracy has become most deeply rooted. The advancement of technology has increased the power of the common man (as evidenced by the effect of the discovery of gunpowder upon the feudal system); and the association of workers in large scale industry has accentuated the sense of power on the part of the masses. Finally, the diffusion of education has tended subtly and inevitably to develop a demand for equality of opportunity.

The problem of autocracy is the conquest of the good things of the earth by overcoming hostile forces which threaten the framework of a particular society, whether that conquest be accomplished by overthrowing external enemies or by overcoming disintegrative influences within the group. The problem of democracy is the equitable division of the spoils, including in that term not only material things but also the spiritual factors of the good life—not merely food, clothing, and shelter, but opportunity and self-respect. In a long view of history we see first one of these problems dominant and then the other. In a time of national crisis we cry out for leadership at any cost, ready to sacrifice all individual interests for common salvation. When times are good, democracy is the order of the day.

The Nineteenth Century was on the whole a period of gradually expanding prosperity and advancing liberalism. New and rich lands were open for occupation to absorb the surplus population. The advance of physical science multiplied a hundredfold the productive power of mankind and released vast possibilities of well-being for the common man. At the turn of the century we looked forward with complete confidence to a world of steadily increasing democracy and progressive international harmony.

During the past two decades all this has changed. The world's surface was largely occupied and the days of pioneering expansion had ceased, yet the pressure of population among nations with an uncontrolled birth-rate continued to increase. The World War came and as its inevitable aftermath a period of aggressive and militant nationalism such as the world had not seen for centuries. The possible gifts of technology were by no means exhaust-

*Presented at the N.O.P.H.N. General Session, Biennial Convention, Washington, D. C., April 25, 1934.

ed. On the contrary we know that science has the resources to bring to every man and woman and child a higher standard of material comfort than even the most privileged have ever known. Yet either our knowledge of the social sciences or our application of that knowledge is so imperfect that we stand hungry and paralyzed before the feast of plenty. Factories lie idle and we lack their products. Food rots and people starve.

A SEARCH FOR LEADERSHIP

The nations of the world face a crisis as acute and devastating as a great war. Inevitably and properly they cry out for leadership, and in many instances for leadership at any cost. In Germany, where need was greatest, every vestige of liberalism has been swept away and a great nation has set itself to the task of turning the clock of world progress back a thousand years. The Courts of Honor which are to be invoked to curb misuse of absolute irresponsible power recall the high ideals of Federalism while the persecution of minorities repeats its worst excesses.

Russia and Italy illustrate precisely the same tendencies though in less marked degree and in both cases with certain counterbalancing forces already manifest. Poland, Austria, Hungary, are on the self-same road. France seems on the verge of fundamental changes in the direction of centralized authority. In the United States a year ago we gladly conferred upon the Federal Government powers which would have been unthinkable in any period of our country's history except during 1917-1918. England alone among the great powers, with her astonishing instinct for combining aristocratic and democratic motives, still treads the older pathway.

MUST NATIONAL PLANNING BE AT A SACRIFICE?

Yet there is a profound difference between what is going on in Germany and Russia and Italy and what is happening in England and the United States and is likely to happen in France. In every one of these nations there is a clear and absolute need for national planning

which is paramount. A changed social and economic order must be established if civilization is to survive. The problem in any individual nation is the price which must be paid for salvation. The peoples which have accepted irresponsible autocracy have despaired of half measures. They have sacrificed all their liberalism, all their democracy, for the building of a new order. England has apparently found a way to move forward with almost no sacrifice. We are trying to do the same in the United States. We accept the necessity for national planning, for an organized and purposeful program which will ensure a richer and fuller life for the individual citizen. We hope, however, to realize that program within the framework of the existing political and economic order and without the sacrifice of the precious values gained through three centuries of democratic ideals. It is an evolution, not a revolution, at which we aim. It depends on leadership and not mastership. We call it "The New Deal." If it fails, there is no recourse but to follow the alternative road.

This, then, is the challenge of today—to the world as a whole, to the nation, and to each professional or business or industrial group within the nation. Social planning we must have. The activities of each group must be so ordered as to yield the fullest results to the whole society in which that group functions. The wider good must rule, and not the selfish interest of any trade or business or profession. This we may take as established.

It is the basis of the Soviet order, of Fascism, of Naziism. It is implicit in the "New Deal." The question is whether such social planning can be accomplished by the group itself under democratic leadership or whether it shall be forced by dictatorship. There is no other ultimate choice but chaos.

No one desires dictatorship, except dictators. The sacrifice of liberalism is always a forced capitulation, a confession of failure. The glorious adventure upon which we are embarked in the United States is the attempt to build the new social order through common coöperative action. The fate of liberal-

ism for centuries perhaps depends on our success.

CAN NURSES PLAN FOR THEMSELVES?

As I have said, precisely the same problem confronts each individual group within the national group. Can the banker, can the industrialist, can the labor leader, can the doctor, can the nurse meet the demands of the new social order without being forced to do so?

That your profession can meet this challenge there can be no manner of doubt for you have already gone far along the road. As I have pointed out in a recent article in the *Survey Graphic* for April, 1934,* "the evolution of public health nursing in the past quarter-century is a social phenomenon of the first importance; and the most extraordinary aspect of the situation is the complete lack of opposition to the new developments on the part of those nurses who have not personally shared in their advantages. In general, social changes which enable the more farsighted members of any group to render better service and secure greater rewards have been bitterly fought by their traditionally-minded colleagues. Why has this not happened in nursing? I do not know—but I suspect the answer may lie deep down in the linkages of the sex chromosomes. I think that women as a class are far freer than men from the ugly defense reactions of narrow group loyalty, far more ready to realize the larger loyalties that arise from a deeper and wider vision of human relationships. If this is the explanation, the nurses may be showing us the way to the solution of many of the problems of a perplexed and divided world."

In the article to which reference has been made, I have pointed out that organization has of course always been characteristic of one field of nursing service, that which is carried on within the walls of the hospital. Even the physician enters into new forms of professional relationship when he joins a hospital staff. The nursing staff, how-

ever, from pupil to superintendent, is completely organized for professional service.

At the present time there are some 120,000 functioning graduate nurses in the United States, of whom one-tenth are in public health nursing associations, three-tenths in institutions and six-tenths in private duty. Nearly half the profession is rendering service on an organized community basis (in home or in hospital) while slightly more than half is operating in the old way as individual professional attendants serving individual clients. It is of peculiar interest to compare the results of the two systems with regard to the satisfactions derived by the nurses themselves and with regard to the service actually received by the patient; and such a comparison shows a striking balance in favor of organized group practice.

ADVANTAGES OF ORGANIZED SERVICE

In material compensation, in the opportunity for continued regular performance of function, in facilities for reasonable rest, recreation and self-development, in security and in progressive advancement in both achievement and reward, the nurse in a hospital or public health nursing staff enjoys advantages unattainable by her colleague in private duty. From the standpoint of the patient, which is, after all, the essential one, the superiority of organized nursing seems equally clear. Organization makes nursing service better and cheaper and more widely available than could possibly be the case under any individualistic program.

The basic ideal which we have universally accepted with regard to health service involves two fundamental principles—(1) that essential medical and nursing care should be provided for all the population, rich or poor, in accordance with their needs; and (2) that such services should be paid for by all in proportion to their financial ability. We cannot too often recall the fact that in 1928 at the peak of prosperity 50 per cent of the families of two or more persons in the United States had family

*"Nurses Show the Way." Our readers will want to read all of this article in the *Survey*, 112 East 19th Street, New York, N. Y.

incomes of under \$2,000 and 40 per cent more had incomes of \$2,000 to \$5,000. The tenth of our population with incomes over \$5,000 can with due providence meet the total cost of illness. The four-fifths with incomes between \$2,000 and \$5,000 can pay part of the cost, while the poorest half of the population can scarcely be expected to accumulate reserves sufficient to carry any appreciable portion of the burden of illness unless they are aided in doing so by some form of organized social machinery.

PRESENT SYSTEM FAILS TO FILL NEED

The theory of traditional medicine is that the individual physician will adjust this complex problem with his individual patient by giving free or part-pay service to those in need and living meanwhile on the fees of the well-to-do. Such an automatic adjustment was possible in the world described by Ian Maclaren in his idyllic picture of "A Doctor of the Old School." It is scarcely feasible in a modern industrial community. That it does not actually work out is clearly indicated by the studies of the Committee on the Costs of Medical Care. They showed that in spite of our free clinics and hospitals the population groups with family incomes below \$2,000 receive less than 40 per cent of the medical service which they need.

It is only by organization that such a problem can really be solved. The visiting nurse association does provide adequate service for rich and for poor with reference to need and not to financial ability. Those who are able, pay the full cost; those who can, pay a part of the cost; and those who can pay nothing, receive care just the same. The difference is met in the end by the well-to-do as it must be in any society where marked inequalities of income exist; but they meet it in an orderly and equitable fashion through taxes or contributions to a community chest and the recipients of service obtain it as a human right and not as an act of individual charity. Only in such a fashion can the resources of medical science be made really available to all the people in such form that they will be actually accepted and utilized.

It should not be concluded, however, that Utopia has been attained in the field of community nursing. There are at least four major problems which I have ventured to outline in the *Survey* article, to which reference has been made above.

FOUR MAJOR PROBLEMS IN NURSING

"1. While it is true that the best organized public health nursing associations provide full-pay and part-pay as well as free services, the full-pay and part-pay services are as a rule poorly developed. The conception of a nursing association as an eleemosynary institution rather than as a social service still persists. There are in most communities considerable numbers of persons who need hourly nursing service and can pay for it but who go without or resort to private duty eight-hour service because they do not know about the hourly pay service or hesitate to avail themselves of it. All that is needed here is courage and conviction and persistent education of the public to develop our public health nursing associations into agencies which are truly universal so far as the economic status of their clients is concerned.

"2. The second defect which exists in our present machinery is the wide gap between hourly service and eight-hour duty. If the nurse who goes into the home for an hour at a time is more efficient and more adequately paid and if her patients are better served as a result of organization, one wonders if the same thing might not be true of the nurse who goes in for eight hours, and of her patients. Certainly it would be convenient for doctor and patient if a single central agency could provide any type of nursing care which might be needed in the home. Surely the nurse who does eight-hour duty would benefit by the stimulus of association and supervision and would profit by the advantages of stable organization. Perhaps some pioneer in nursing will work out a coördination of public health association and registry or a wholly new type of community service which will approximate such an ideal.

"3. Growing still bolder, we may

raise the question whether even the separation between home nursing and hospital nursing need be as sharp as it is today. Clearly a nurse at a given moment must be operating either in an institution or in a household. Yet we may perhaps visualize a situation in which the staffs of hospital and community nursing groups might be more or less interchangeable. Physicians benefit greatly by continued hospital contacts. Perhaps nurses might do the same. Certainly the possibility that a cherished nurse might continue in the home the service she had begun in the hospital would be a great comfort to many a patient. Under an organized coöperative plan worked out through a Joint Council on Nursing such an arrangement might be more common than at present.

"4. Finally, there remains the problem of working out an adequate plan for payment by the great middle economic group of the population. The crux of the whole question is the unequal incidence of illness, as the Committee on the Costs of Medical Care so clearly showed. One family out of a hundred in a given year must pay out a quarter or more of its total annual income for medical care. The obvious and only way to meet this situation is by some application of the insurance principle, that is by the accumulation through fixed annual contributions from a group of a reserve to pay for the emergencies of illness when they ultimately arise. The very poor cannot even contribute to a sickness insurance fund and the very rich do not need to do so. In between is a major section of the population which could bear the cost of medical care and hospital care and nursing on an average annual basis but cannot meet the expense of an illness when it comes without such previous provision. The American Hospital Association is supporting an admirable plan for insurance to cover hospital costs (including ordinary nursing costs). This program should be widely supported and its basic principles might well be embodied in annual payment plans for the support of the visiting nurse association which renders care in the home."

There is much yet to be done before the best of nursing care is available to all persons, for all conditions, in home and in hospital and on terms which make it actually acceptable to the recipient. Yet the degree to which this ideal has been approached by the nursing profession as organized in hospitals and public health nursing associations is nothing short of phenomenal. The nurses have shown us the way. They have taught us that in union there is strength—that organization for community service promotes efficiency and morale in the server and economy and self-respect for the served.

THE GRAVEST PROBLEM—OVER-PRODUCTION

It is impossible to analyze even in the briefest fashion the situation which confronts your profession without reference to the gravest problem of all—that presented by the overproduction of personnel. The early reports of the Grading Committee revealed an appalling rate of increase in graduates of nursing schools. In 1900 there were 11,892 registered nurses in practice; in 1910, 82,327; in 1920, 149,128. Even before the economic crisis of 1929 the number of graduate nurses was so greatly in excess of the demand that there was widespread unemployment. Since that time the situation has become increasingly tragic. Yet the overproduction by the training schools has continued practically unchecked. Comparison of the second grading of 1932 with the first grading of 1929 does indeed show a decrease in the number of schools from 1,885 to 1,620, a substantial gain. But the total number of new graduates increased from 23,810 in 1929 to 25,312 in 1932.

In many other respects a comparison of these two gradings of the nursing schools of the country is highly encouraging. A recent tabulation of findings with regard to 171 separate items of appraisal showed that 128 items or 75 per cent had registered changes for the better within the three years. Yet the really basic evil of overproduction had grown steadily worse up to 1932. During the past two years, however, studies made by the *American Journal of*

Nursing show a turn of the tide with many schools admitting one class a year instead of two and some schools taking in no more students.

The Grading Committee has emphasized the urgency of this problem. It has shown that the smaller school—if it makes even a partial attempt at an educational process—is actually losing money by the venture and could operate more economically with a graduate staff. The Committee is a fact-finding body, not a propaganda organization. Machinery for grading can improve schools and it is doing so. It can only control numbers, however, by causing the closing of the poorest schools and this must be a gradual influence and quantitatively a minor one since the worst schools are generally the smallest. The problem must be met by the training schools themselves and by the nursing profession as a whole. The alumnae of each school could if they desired bring to bear an organized pressure for limitation of numbers which might conceivably be effective in many instances. If this fails, I can see no hope except in a program of extensive publicity warning the young girls of the country that this profession is woefully overcrowded and that there is no place in it except for the unusually competent and well qualified and well educated applicant.

BACKGROUNDS OF PUBLIC HEALTH SERVICE

Finally, let me call your attention to the urgency of certain still wider problems of community planning which are your concern as nurses but also and even more as citizens. I refer to the basic background of community health machinery which conditions and makes possible your own work in your own special section of the wider field. No physician, no nurse, can accomplish maximum results without this background for his or her individual labors.

You are well aware that even before the economic depression we had only gone about half way along the road to a really adequate public health service for

the United States. We had made a real beginning; but Professor I. V. Hiscock has recently pointed out that between 1915 and 1929 annual state expenditures for health and sanitation increased from 10 to 26 cents per capita while expenditures for highways increased from 23 cents to \$1.82. One hundred large cities expended for health services 77 cents per capita in 1929 as compared with 59 cents in 1923, while seventy smaller cities expended 78 cents per capita in 1929 as compared with 70 cents in 1923. Per capita expenditures for police and for fire protection and for highways were in each case from four to six times as high as expenditures for health protection and those for education were twenty to forty times as high. In 1929 only three or four states, not more than twenty cities, and not over a dozen rural counties in the United States had really adequate community health organizations and two-thirds of our two thousand rural counties were without a full-time health officer. In the years since, even the modest results already attained have been seriously threatened by the economic depression and especially by the demand for tax reduction which has swept the country. In states like Alabama health services built up through years of effort have been almost completely wrecked and in many others damage of the gravest kind has been suffered. Many states have lost a quarter and some a half or more of the funds previously allotted to health.

The recently issued Census of Public Health Nursing in the United States* brings concrete evidence of shortcomings in that area of the public health field with which you are specially concerned. The minimum standard of adequacy (and a very low minimum) is one public health nurse for each two thousand persons in the population. In 1931 there were four states (Connecticut, New Hampshire, Rhode Island, and Massachusetts) which had a ratio as good as one nurse to every 3,000 persons. Twenty-six states had less than one nurse for every 10,000 persons. Seven of these states (South Carolina, Texas,

*National Organization for Public Health Nursing, 50 West 50th Street, New York, N. Y.
50 cents

Arkansas, South Dakota, North Dakota, Oklahoma, and Mississippi) had less than one nurse for every 20,000 persons. In Mississippi there was less than one nurse for 50,000 persons. Between 1924 (when the last census was taken) and 1931, thirteen states (New Hampshire, Nebraska, Nevada, Tennessee, Kansas, Utah, South Dakota, North Dakota, West Virginia, Louisiana, Oklahoma, Alabama, and Mississippi) actually showed a decreasing ratio of public health nurses to population.

Is this wise national policy? Is it sound economy?

WHAT KIND OF ECONOMY ARE YOU BACKING?

We need economy in government as we need it in the conduct of our individual lives; but economy is not synonymous with a senseless panic of budget-slashing. "Economy" comes from a Greek root which means "wise management" of the household or the state. It does not mean refusing to spend money. We have another word for that—parsimony. Economy means spending money wisely. If a dollar spent in one way saves two dollars spent in some other way, it is "economy" to spend the dollar. Beyond reasonable limits reduction in budgets becomes not an economy but an added economic burden. False economy piles up its bill with compound interest and the tragedy of it is that little children who had no part in the affair must help pay for the health bankruptcy of a community.

Less than two-thirds of a cent out of each tax dollar goes for public health or an average of fifty cents per person in the United States, while we know from experience with cities and counties having adequate health service that one dollar from official sources (supplemented by a similar amount for public health nursing services, tuberculosis associations and other voluntary agencies) is a minimum for adequate health protection.

Two dollars will buy three hundred cigarettes, a theater ticket, two or three pounds of candy, or a dozen gallons of gasoline—things gone and forgotten in a day or a week. The same sum spent by

each member of a community will buy for a whole year a clean and sanitary city, freedom from typhoid fever, scarlet fever, and diphtheria, normal motherhood and healthy children.

If we consult our dictionaries we shall find that the first definition of a "tax" is a "contribution levied on persons, property, or business for support of government." A second meaning of the word is a "strain or heavy demand" upon a person or a community. We hear a great deal today about the first kind of taxes. It might be wise to give some thought to the second.

OUR STERNEST TAX COLLECTORS

From the standpoint of "strain or heavy demand" some of our most exacting tax collectors are the germs of the communicable diseases. In 1900 the bacillus of tuberculosis taxed the people of the United States to the tune of 195 lives for every hundred thousand persons in the population. That is, this tax collector took the life of one person out of every five hundred each year. In addition it collected the cost of medical and hospital care and the cost of supporting in partial or complete idleness at least one person out of every one hundred and fifty.

By 1930 the death rate from tuberculosis had fallen from 195 to 67 per 100,000. We had reduced the tax paid to this public enemy to one life out of every fifteen hundred persons in the population, with a similar reduction of two-thirds in the burden of sickness and disability. This is a sort of tax reduction which is well worth while.

The question then is not whether we shall pay taxes or not, but how much we shall pay and for what. We can contribute a small sum to our health departments and clinics and nursing associations and tuberculosis associations for prevention; or we can pay a much larger sum as a tax on un prevented disease for the care of the sick, the support of the invalid, the burial of the dead, the gradual replacement of lost man power. We have reduced the tax levied by disease during the past thirty years to a fraction of what it once was. We cannot afford to let our

progress be nullified by the panic parsimony which is the enemy of true economy.

RESTORATION AND BUILDING FOR THE FUTURE

We are on the up-grade now and it is time to restore what has been lost and to build wisely and boldly for the future. Economy, efficiency, social idealism, the American dream of equal opportunity, demand efficient health machinery. The people of this nation are entitled to a square deal in health protection. Are we to be satisfied merely with emergency defenses against outlawed plagues like cholera and smallpox? Are we, in the new era, as in the one just passed, to be content with a half loaf of health? Or shall we set as our goal the maximum of health—a guarantee against all preventable sickness and provision for that fullness of vitality which makes living a joy and a delight?

If such an ideal is to be realized we need, first of all, a far more vigorous support of city and county and state health departments and of local voluntary health agencies. The latter are in many communities considering retrenchment and talking of turning over their work to official departments—at the very time when those official departments are being crippled by indiscriminate tax-slashing and in some instances (as in the state of Indiana and the county of Los Angeles) by organized medical sabotage. As citizens we must see to it that no selfish vested interests, either business or professional, shall prevail against the public good. We must defend what we have and we must see to it that health protection is made an essential part of the social reconstruction of our individual communities. As President Roosevelt said when Governor of New York State, in submitting the notable report of his State Public Health Commission, "The success or failure of any government in the final analysis must be measured by the well-being of its citizens."

*For recommendations in regard to combined services see the *Survey of Public Health Nursing: Administration and Practice*, The Commonwealth Fund, 41 East 57th Street, New York, N. Y., and the report of several successful combinations in Miss Haupt's article in this magazine, page 349.—*The Editors.*

TWO DOLLARS PER CAPITA

One dollar per capita from the official budget is an absolute minimum for health protection and a total of two dollars for official and voluntary agencies combined is essential for adequate service. We need, and for a long time shall need, both official and unofficial agencies in the health field. Ideally, perhaps, all social welfare problems should be solved by the State. Practically, a given service should be carried at a given time by the agency which can carry it most effectively. At present, and perhaps always, certain activities can be performed better by a private agency or by coöperation between a public and a private agency than by an official agency alone. This is notably true, I think, of public health nursing.*

EXTERNAL AID FOR RURAL TERRITORY

Local funds and local leadership can solve all of our problems in urban communities. The rural areas of the United States are in a different case. We must face squarely the fact that such areas in many states and that certain predominantly rural states as a whole lack the financial resources to set up adequate health machinery without external aid. At the present moment our most urgent need is for federal aid to rural areas throughout the United States which cannot support an adequate health service of their own. The meagre appropriations made for this purpose in the past have been entirely withdrawn with results which are disastrous in the extreme. The national health organizations of the country have prepared a definite program which calls for an appropriation by Congress of two million dollars for saving the wrecked and disorganized health services of our rural areas. Congress has just appropriated thirty-eight million dollars for new naval armament. Can we not afford two millions for national defense against the menace of preventable disease?

Finally, we need for the future a comprehensive national plan for the co-

ordination and evolution of our Federal, State, and local health services; and in this era of general national planning it is time that the health of the people should find its place. Every previous crisis in our national history has been met with renewal of courage and has resulted in a tangible and actual advance—not a retreat—in the fields of health and social welfare. We should not be content today with merely defending the ground already won. We should draft a bold and constructive national health program. We should

visualize a coördinated and strengthened federal health service, a competent health department in every state, a full-time adequate health service in every local community, urban or rural. We should outline sound lines of relationship between official and non-official health agencies and the medical profession. We should mobilize in this cause all the intelligence and courage and latent idealism of the American people. that equality of opportunity for every child born in this land may become not only a dream but a reality.

DEDICATION OF THE JANE A. DELANO MEMORIAL



International News Photo

On Thursday afternoon of the Biennial Convention week, the crowds of nurses and their friends paused for a brief hour to dedicate the Jane A. Delano Memorial statue to the 296 nurses who died in the World War. The statue, symbolizing the spirit of nursing and designed by Dr. R. Tait McKenzie, stands on the grounds of the Red Cross building and has been effectively landscaped. Anna W. Kerr, a friend of Miss Delano's, unveiled the statue as taps were sounded, and Elnora E. Thomson, Mabel T. Boardman, Major General M. W. Ireland, and Lucy Minnegerode spoke briefly of Miss Delano and the war days.

We believe nurses throughout the country will be proud of this—our own—memorial to the nurse victims of the war. If the war had to be and nurses had to die, this seems a fitting tribute to their memory. Let us hope, however, that there will never again be occasion for another such dedication.

Community Responsibilities for Safeguarding Motherhood

GEORGE W. KOSMAK, M.D.

Editor, *American Journal of Obstetrics and Gynecology*

ONE of the greatest advances of the last century is the gradual growth of the idea that in questions of life and health, there is a responsibility beyond the individual and that such responsibility must be assumed by the community, including in the latter term not only a local, but a state- or nation-wide participation. This is not to be regarded as an admission that cases of illness must be handled *en masse* but rather that the individual in preserving his own health, protects that of his neighbor.

This idea grew as those great advances in medicine were published with which are associated the names of Jenner, Pasteur, Koch, Holmes, Semmelweiss, and a host of others, all of whom by their epoch-making discoveries contributed in founding what we today recognize as the science of preventive medicine. And prevention required coöperation between the public, physicians and officials invested with regulatory and police powers. Therefore the individual in the picture gradually became subordinated to the group in so far as the handling of certain major problems in medicine was concerned. In other words, he became a spoke in the wheel or a cog in the machinery, though a most essential one. And this applies with great force to obstetric practice whose shortcomings, if there be such, are not the concern merely of the doctor and the nurse. For the safeguarding of motherhood is a reflection of the state of civilization in any given country, just as much as the handling of the contagious disease problem, and in order to provide for the successful carrying out of one of woman's highest functions coöperation of

interests is essential. And that is why so much public attention has been given in recent years to what is regarded as an unnecessarily high mortality rate from childbearing and why the efforts to study and correct this condition have developed from an individual to a community problem.

For the loss of mothers often means the loss of babies and we need at the present time all the sound mothers and healthy babies which the country is capable of producing. The fetish of over-population which has been so vigorously stressed at different times during recent years, does not concern most of the white races. The Anglo-Saxon birth rate, as that of certain other nations, is declining rapidly and competent authorities have demonstrated that birth rates and death rates are approaching each other to such a degree that our population will soon be stationary. Healthy growth is essential to progress; a cessation means decline. The causes for the diminishing birth rate need not be elaborated here but they are not far to seek. Sterility, both natural and acquired, is an accompaniment of an advancing civilization and every effort must therefore be made to conserve all available sources of fertility, so that national growth and population balance may be maintained.

So-called family limitation, especially among the intelligent and healthy, the postponement of conception after marriage until a convenient time and blind adherence to much of the widespread and unreasonable birth control propaganda, must be taken into consideration in a study of the problem of maternity. More attention must be accorded to the preparation for childbearing and less to

*Presented at the N.O.P.H.N. General Session, Biennial Convention, Washington, D. C. April 26, 1934.

avoiding pregnancy,—a prospective mother if otherwise normal and healthy is well able to bear its responsibilities and every effort, individual and collective, should be extended to aid her in this natural function. This can be accomplished by providing her with good medical and nursing services based on safe, sound and accepted procedures which are in the province of most communities to grant through their doctors, nurses and hospitals and, if not, then the effort must be made to supply the need by whatever means are found most suitable.

THE MATERNAL MORTALITY RATE

Unfortunately, one must admit that the puerperal mortality rate in the United States is not creditable to our otherwise high standards of material well-being. To what may this be ascribed? Our medical schools and their graduates are admittedly of a high order, many of our hospitals are marvels of convenience and luxury, lay interest in providing prenatal and nursing care is most noteworthy, and yet we have a death rate in this country of between 5 and 6 per 1,000 live births. Is it too high? This may be answered in part by the claim of competent authorities that at least one-half of the puerperal deaths are preventable. That is to say, if adequate and satisfactory maternity care had been provided, these women would not have died in bearing children. Now do these presumably preventable deaths depend on the attendants,—doctor, nurse or midwife, or on the patients themselves, or on the hospitals in which the confinements take place? Those who have given thought to the problem believe that the responsibility in varying degrees rests upon all of these agencies.

In an attempt to gain a more specific knowledge of the question let us examine in some detail the latest of these studies,—namely the report recently issued by the New York Academy of Medicine, and published by the Commonwealth Fund,* which deals in a

very comprehensive manner with the maternal deaths which occurred in New York City during the three-year period from 1930 to 1932 inclusive. Each death was carefully studied within two or three weeks after it occurred by a special advisory committee appointed by the New York Obstetrical Society, the necessary data being first secured by physician investigators. After establishing the true cause of death, it was felt that a determination of the proportion of the fatalities which could have been avoided was one of the most valuable objectives of the study. The criterion was that of the best possible skill, both in diagnosis and treatment, which the community could make available. At the same time an endeavor was made to lodge the responsibility, whether attendant, patient or hospital. Out of all the deaths, 2,041 in number, 1,343 were adjudged preventable by the advisory committee of obstetricians. Among those ascribed to the physician, faults of judgment and technique seem to predominate and it was quite evident that there was a tendency on the part of the attendants to underrate the seriousness of obstetric operations. But the doctors did not receive all the blame,—in over 36 per cent of the cases, the responsibility could be ascribed to the patient; mainly lack of coöperation and actual failure to obtain suitable care even where this was available.

CAUSES OF MATERNAL DEATHS

It may be of interest to note the causes of death in this series and certain other outstanding features which this Report presents. We can only form an intelligent opinion and discuss preventive measures when the facts are at hand. In the first place a startling thing is that 357 out of a total of 2,041 deaths followed abortions, of which 262 became septic. The figure naturally is inaccurate; there were probably more fatal cases in which deaths were ascribed to some other cause, but evidently the public is not yet impressed sufficiently with the danger of abortions. One hun-

**Maternal Mortality in New York City.* New York, N. Y.

The Commonwealth Fund, 41 East 57th Street,

dred and twenty deaths followed ectopic gestation, many of which were judged preventable because of evident lack of competent attention. Women must be impressed with the gravity of certain symptoms that may seem mild in character but denote serious conditions. In the remaining 1,564 cases hemorrhage caused death in 197. Many factors contributed to these deaths but repeatedly there was noted a failure to employ all of the available procedures to control and combat hemorrhage. Minimizing the gravity of bleeding during pregnancy by the patient as well as by the attendants was noticeable and the conduct of the delivery was frequently improper, according to accepted standards. The number of deaths from sepsis was 510, or about one-third of the total, excluding abortion and ectopic. A point to be noted is that the septic rate was approximately five times as high following operation as spontaneous delivery and twice as high in hospital as in home deliveries.

Two hundred and thirty-one women died of toxemia, including albuminuria and eclampsia. Since prevention is the most important factor in handling this complication of pregnancy, it should be noted that only 26 per cent of these patients had had adequate prenatal care. This fact demonstrates the importance of educating women in the vital necessity of putting themselves under supervision early in pregnancy and coöperating with their physician scrupulously throughout the prenatal period.

Shock and accidents of labor accounted for 171 cases, including all those in which death was ascribed to the effects of labor and the accidents which occurred during its course. The accidents include spontaneous rupture of the uterus, inversion, placenta previa, premature separation of the placenta, sudden, overwhelming toxemia, and uncontrollable hemorrhage. These are usually regarded as acts of God to be accepted as an unavoidable hazard of childbearing. It is a matter of interest, however, that a liberal estimate of the number of such accidents places them at only about 18 per cent of the total

fatalities, excluding abortions and ectopics.

After considering all the deaths due to strictly puerperal conditions, there remained a group, 344 in number, in which the actual cause of death was a condition not directly connected with pregnancy, but one which was unfavorably affected by it or by the delivery. This group included many intercurrent diseases, principally cardiac and respiratory, most of which were regarded as unavoidable.

Cesarean section received special consideration in this Report because of the large number of fatalities associated with the operation. Three hundred and four deaths followed cesarean section, or almost 20 per cent of the total. A careful scrutiny of the cases by the advisory committee resulted in the statement that at least 256 were preventable and that a great majority of these were due to faulty judgment and lack of skill on the part of the attendants.

HOSPITAL VERSUS HOME DELIVERY

After analyzing the home and hospital deliveries the Committee concluded that the hospital is, and probably will remain, the only safe and proper environment for the care and management of the abnormalities of pregnancy and labor. It must be noted, however, that the greatly increased hospitalization of parturient women in the past two decades has not brought a corresponding reduction in the puerperal morbidity and mortality, notwithstanding the advances in medical knowledge and the improvement in hospital facilities. Evidently the situation demands further inquiry, but in the meanwhile it would appear as if we might have to revise our ideas about the apparent disadvantages of home confinements, at least in certain population groups. While confinements in hospitals may seem preferable from the standpoint of economy and convenience, we must not lose sight of the fact that safety in the final outcome depends on the character of the environment and facilities which the institution affords. If these are not of the best, safety is sacrificed.

The Report finally gives extended consideration to midwife practice. It is of interest to note that about 9 per cent of the deliveries in New York City are still conducted by midwives, who number over 850, and when once licensed operate year after year with only nominal inspection by the nursing force of the Health Department, nurses who themselves are untrained for the work. The rules and regulations imposed by the Department are honored in the breach rather than in the observance, and reform is greatly needed. There were 48 deaths among the women delivered by midwives, or a rate of 1.6 per 1,000 live births. This is slightly less than that for cases delivered by physicians in homes, although the comparison is not really justified because not all deliveries attended by physicians at home terminate spontaneously. Of the midwives who had been in contact with fatalities and were interviewed by the investigators, less than one-third were judged to be competent. In New York City, as elsewhere, proper training, supervision and control of midwives is imperative as long as they are in the field, and there would seem to be good reasons for retaining and developing them as adjuncts to physicians until a substitute can be found. At present, or even in the near future, that does not seem likely.

The quality of hospital service entered the picture very, very frequently. Many institutions caring for maternity patients are of high grade with definite adherence to accepted standards of practice but many, especially those of the proprietary type, should not be permitted to claim such designation. It became more and more evident as the inquiry proceeded that some sort of supervision and control of proprietary hospitals in particular, was essential. Hospital confinements by no means spelled a *safe* confinement; facilities for the proper care and delivery left much to be desired and the unrestrained activities of the attendants very frequently verged on absolute incompetency if nothing worse.

I have considered the New York Re-

port on Maternal Mortality somewhat in detail because it affords a close, localized study of a large group of cases. The findings, however, vary little from those of similar studies comprising a wider area, such as the investigations of Plass, and of Adair, Holmes and Mussey, which included groups of from 12 to 15 scattered states; the recently published report of Rothert of the Federal Children's Bureau, the Cleveland survey by Bolt, and others. All seem to point out the same things: lack of prenatal care; a too high incidence of operative interference with associated incompetence of attendants; inadequate and improper institutional facilities for maternity patients with lack of official inspection and control of their equipment and practice; need of supervision of midwives, together with their adequate training; and better education and instruction of doctors and nurses as well as enlightening the public in matters obstetric.

And why have I brought these detailed references to such reports on our puerperal mortality to the attention of this nursing group? It is because I believe that the nurse occupies an important position in any scheme to achieve better maternity care, not only as an individual practitioner but in a larger sense as a participant in the carrying out of certain much discussed recommendations and reforms. And how best can the latter be instituted? I have become impressed more and more as I have studied the subject that community interest must be stimulated and local conditions bettered by local agencies before any definite and permanent results can be achieved. This will mean a union of forces—doctor, nurse, public officials, and finally the people whom they serve. Such community councils are in a better position to learn about and act upon their home conditions than are central governmental agencies far removed from the field of activity. The value of the latter in an advisory capacity or for purposes of investigation and research, is not to be denied. The medical profession should take the lead in organization and should be stimulated

to do so; but satisfactory results can only be obtained if the allied professions and agencies are actively interested. County medical societies, nursing groups, women's clubs, and other organizations should unite in developing a program of education in adequate maternity care and then take steps to secure and provide it.

Childbearing has not had a fair deal,—too much thought and attention have been given to the avoidance of pregnancy. Possibly the constant parading of the horrors of childbirth in our popular magazines and elsewhere has stimulated a fear of this process, perhaps there are other reasons. It is essential that we develop a more rational state of mind, in which pregnancy will be regarded as a desirable rather than an undesirable happening. The birth rate of the nation must be preserved and kept above the death rate for obvious reasons. To do so it is essential that we have healthy mothers and healthy children, and these can only be assured if we surround the act of childbirth with every safeguard. I desire to reiterate my belief that this can be best secured by developing a community interest in the matter. Perhaps this should begin with an evaluation of the local facilities through the medium of a carefully conducted, impartial survey by a selected group as already noted. If these local facilities are found wanting, and do not accord with accepted standards, then the necessary steps to provide them will be based on a more substantial background.

It must be evident to anyone who has given due consideration to the subject that the problem of providing adequate maternity care in any given community, is one of many angles. There are individual and there are collective responsibilities. Can they be ignored, since authenticated investigations have forced the admission that there is need for improvement? Should we accept with equanimity a hazard for childbearing which spells the death of over 5 women in every 1,000 pregnancies? And when competent judges have classed over one-half of these deaths as preventable, a

prompt and satisfactory answer becomes even more imperative. I have already referred to the number of careful studies dealing with the subject which have been made in this country. The results of these warrant certain conclusions as to the remedies: better teaching of obstetrics to doctors, nurses and midwives, adoption of adequate standards for practitioners and hospitals, community control of the latter as well as midwife practice, and finally, making the public acquainted with its own responsibilities. Even if we acknowledge a possible hazard associated with pregnancy, and this is a tangible hazard, should we accept without question a situation in which half of the deaths might possibly be prevented? While no one can say definitely that such reduction is possible immediately, an effort at least should be made to attain this result. And in order to bring about an improvement in the shortcomings of obstetric practice commensurate with our otherwise high standards of living, cooperation between the parties interested is essential and paramount. As I have already stated these are the physicians, the nurses and the public. Consideration of the participation of the former we can dismiss, this must be taken care of elsewhere, but the rôle of the nurse should prove an appropriate source of discussion on this occasion.

THE ROLE OF THE NURSE

There is no branch of medicine in which the services of the nurse have come to be regarded so essential as in obstetrics. From time immemorial women in labor have felt the need of those ministrations which only the sympathy of another woman could supply. And in the course of time specific knowledge of the requirements of a woman in labor resulted in the development of the midwife, who held her place for centuries as the arbiter of the lying-in chamber. Then, as scientific knowledge of obstetrics superseded the guess work and superstition of earlier years, the medical profession gradually took over the functions and prerogatives of the midwife,

with the exception of certain countries where she continues to be regarded as an essential feature in this field of practice. The trained nurse as we have come to know her today assumed the function of a bedside assistant to the physician. But when social service work in medicine developed we find the nurse coming into the picture in a new rôle which demanded the exercise of other abilities and other methods of training. About these we have not as yet reached full and satisfactory conclusions.

The White House Conference Report showed the lack of uniformity and the shortcomings of nurse training in obstetrics as it did in that of physicians. The Committee which undertook to study the problem concluded that both the academic, as well as the practical training of nurses, needed revision. It was felt primarily that nurses as a class were not fully appreciative of what adequate maternity care implied or of the underlying causes which contribute to the morbidity and mortality from childbearing in so far as their own participation in the matter was concerned. Which means, in part at least, that they had little understanding of the value and significance of the individual procedures employed in obstetric practice. Consequently we may assume that nurses do not really know that a certain number of puerperal deaths can be prevented and that proper and skilled nursing care plays an important part in such prevention. In view of the responsibility which has been placed on nurses in their comparatively new activities in the field of public health and closely allied types of nursing, they should be better equipped for these tasks. For how can we expect them to instruct prospective mothers when a carefully conducted survey, such as that described in the White House Conference Report, has demonstrated their own lack of knowledge in this respect? Nurses acquire a more intimate contact with patients in many instances than do the doctors and what can be worse than influence based on ignorance of fundamentals? Perhaps our teaching methods

are at fault and probably we have emphasized the "how" in our hospital routines rather than the "why". To do satisfactory and intelligent work, nurses must be shown how to think as well as to act. This may prove a difficult task but I believe that much can be accomplished by a simplification rather than an expansion of the nursing curriculum, with greater attention to the practical phases of their work. A competent obstetric nurse must develop certain mental qualities including quick observation and the ability to deal with emergencies. I feel that this is more dependent upon a well grounded knowledge of the underlying facts in obstetric physiology and procedures than upon a smattering of theoretic knowledge, such as the details of blood chemistry in toxemia, the histology and pathology of the female generative tract, or the technical details of the low flap cesarean section, and other topics which are apt to be made much of in the nursing curriculum.

TRAINING FOR MATERNITY CARE

Another vital fact brought out in the White House Conference Report was the need for competent instructors. This investigation disclosed lamentable lack of sufficiently trained supervisors in the delivery rooms, wards, and clinics of many hospitals which aim to teach obstetric nursing. Less than one-half of the instructors had any postgraduate training and apparently few had had teaching experience. The student's experience in delivery rooms was usually that of a scrubbed assistant and in only a small number of schools (14%) was she afforded an opportunity to manage even one labor, in order to give her some idea about what to do in the emergency delivery which most nurses are likely to meet in their subsequent careers. Antepartum and postpartum clinic attendance is likewise neglected in many hospitals, and home deliveries or instruction of mothers is taught, if taught at all, in a very incomplete fashion, not commensurate with its great importance. A continuous contact of the pupil nurse with a maternity patient, in so far as this is feasible, should be provided

through the antepartum clinic, the labor room and the postpartum ward. The conduct of normal labor should be stressed and given an interest and importance equal to that of forceps, version, cesarean section or other complicated obstetric procedures. Until we can base the doctor's and the nurse's knowledge and experience on the elementary and accepted principles of obstetrics, we cannot expect a diminution in our maternal morbidity and mortality figures. For conservatism must be impressed upon our obstetric attendants, as well as on the public, because untimely interference with the natural forces of labor and resort to short cuts in delivery by operative procedures, have contributed more to our high maternal and fetal mortality in recent years than have all those accidents of labor over which unfortunately we have at the present time little or no control.

And now you may well ask what has the nurse to do with what I have just said and what has it all to do with the title of my address? To begin with, I feel that in any community effort to provide adequate maternity service the nurse bears an important and responsible part. For this she must thoroughly prepare herself, whether as a teacher in the hospital ward or delivery room, as a visiting nurse to prospective mothers, or as an assistant to the doctor in home deliveries; whether in a somewhat newer and yet undeveloped function as supervisor of midwives, or finally, as an actual midwife practitioner under certain and as yet not fully defined conditions.

THE NURSE-MIDWIFE

Community health organizations have come to realize the value and importance of the well trained visiting nurse, and maternity work constitutes an important element in her activities. Such nurses should be thoroughly grounded in the principles of obstetrics in order to be of the greatest assistance to their respective communities. Perhaps it would prove a radical suggestion that nurses in such positions should have had a midwife training. Let us analyze briefly the midwife situation in this country as a preliminary to my sugges-

tions. Midwives do from 8 to 10 per cent of the deliveries in the United States. Their work is good, bad or indifferent, mostly the latter. They are surrounded by restrictions, rules and regulations, which are seldom enforced. There is evidently a demand for their services and they still compete to some extent with the doctor and the hospital. They may possibly be spared where other substitute agencies are available, but undoubtedly there are industrial and isolated rural communities where they can do effective work. But this must be supervised by medical agencies and a new scheme worked out for this country in which the shortcomings of the present midwife system may be overcome. I believe that for the present, at least, the midwife must be recognized but those now in practice must be more satisfactorily supervised and controlled, and I further believe that this can be most satisfactorily done by trained nurse-midwives working under the local health administration. An attempt to educate and train nurse-midwives for this purpose is being made by the Lobenstine Clinic in New York City and its graduates would also be available for activities such as the Frontier Nursing Service in Kentucky, and for similar organizations. This is a new and important field for the trained nurse who possesses the proper mental and physical qualifications for the task. Notwithstanding an opposite tendency in recent years, home confinements of acknowledged and probably normal cases, cannot and should not be eliminated; they can be made as safe as hospital confinements, perhaps safer than some; for overcrowding, especially of public hospitals, and the lack of isolation from patients with other illnesses, such as occurs in many of our institutions, particularly those of the proprietary type, often spell disaster for the prospective mother. A hospital confinement is not to be interpreted necessarily as a safe confinement, for the designation "hospital" covers a multitude of sins. Unless good accommodations and services are available, the average normal obstetric patient un-

doubtedly is safer in her home surroundings, under the care of a competent physician or midwife than in a poorly equipped and over-crowded hospital. There are limits to midwife practice and for these the community must provide. In the meanwhile the medical profession and the public will have to be convinced that midwife practice properly controlled and supervised will have a favorable influence in reducing our high maternal mortality rates.

A COMMUNITY-WIDE PROJECT

The various matters which I have now discussed will require community effort for their development. We are all interested primarily in an effort to reduce the deaths from childbearing, especially since we know that a goodly proportion can be prevented. No single doctor and no single nurse will come into contact with many individual fatalities but the aggregate number of puerperal deaths per annum in the United States is about 16,000. If of these

16,000 deaths, even one-half could have been prevented, is not the effort worth a trial? And in this effort all interested parties must participate, including the doctor, the nurse, and the public, and preferably through local community effort. To those who serve the community as members of the board of directors of visiting nurse associations, I make a special plea that you provide nursing care to every patient in her home at the time of delivery, and further that you arrange your budgets and your plan of work so that the prenatal service need not suffer because of the seasonal demands of influenza, measles, or staff vacations. I have faith that an improvement in our maternal mortality statistics will result if we set our minds on the task, and that it will be by a coöperative movement such as I have ventured to propose. The nurse is an important factor in its success, for she represents, or should represent, that human element in the problem, without which success would be doubtful.

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Federal Aspects of Unemployment Among Professional Women*

BY ELLEN S. WOODWARD

Director of Women's Work, F.E.R.A.

I AM very happy to be here this morning—it is an inspiration to me to look into the faces of you who represent this great organization—the American Nurses' Association. I know of no national organization which has made a greater contribution to the public welfare.

Without your intelligent and sympathetic coöperation, the Women's Work Division of the Federal Emergency Relief Administration could never have done what it has for unemployed nurses. In giving jobs to nurses, thousands of other individuals have been directly or indirectly benefited. So, I repeat that without your aid, much that was done for women of your profession would have been left undone, and consequently greater distress and suffering would have been experienced by those whom the nurses served. Your associations have rendered a great national service in this emergency. There is no one who has had more concrete evidence of this fact than I have. I want to thank you on behalf of the F.E.R.A.—I do thank you—as an organization, as members of committees, and as individuals, for all you have done.

Civil Works has ended—demobilization has been effected. It seems to me almost prophetic that the day set for beginning the new relief program was Easter Sunday, April 1. Aside from giving temporary relief, this new long-range program has many elements designed to eliminate causes, and thereby to effect lasting cures. Who, better than you of the nursing profession, can understand that some such procedure is essential, if permanent good is to come of any "treatment" of our relief problems.

Since you are directly interested in all welfare activities, there are many phases of the new relief program, as it is now being developed, that will claim your special interest and, I feel sure, will appeal particularly to your professional ideals.

More than ten thousand nurses were put to work under the Civil Works Administration. Each of you is familiar with how the coöperation of your organization was asked, and how splendidly it was given through national, state, and local committees working with the Relief Administrations and more particularly with the State Director of Women's Work. Nurses were given employment in many ways—in public hospitals, institutions, clinics, on public health staffs, bedside nursing, immunization campaigns, in making surveys and in many other health services. It is hoped that these services have opened, and will continue to open, new avenues of employment to the qualified, unemployed nurses. In many instances health and nursing service were carried to remote sections for the first time. The need for such services is constantly with us. The Civil Works program served to emphasize these needs.

VARIOUS STATE PROJECTS

The reports from State directors of women's work on nursing projects invariably state that it is impossible to put into written words and figures an adequate report of the accomplishments. In the State of Washington, for instance, the public health department had long been hampered in its work because of the necessity of curtailing expenses. CWA gave them an opportunity to employ three hundred needy nurses. Some

*Excerpts taken from Mrs. Woodward's address through the courtesy of the American Nurses' Association, before whose meeting this address was given at the Biennial Convention Washington, D. C., April 26, 1934. Published also in the *American Journal of Nursing*.

of these nurses had to be given clothing and shoes before they could accept work. With the corps of three hundred additional nurses, supervised by the public health nurses, from December 8, 1933, to March 15, 1934, thousands of children were immunized against diphtheria and were given smallpox vaccination. In the flood area, hundreds were given typhoid vaccine. The figures themselves are truly startling, when one realizes that only three hundred nurses did all the work in that State in such a short time. Behind the figures, I am sure, each of you can visualize what actually happened, and how much human suffering has been relieved. Here is the record:

Number having bedside or nursing care	4,668
Number visits to TB patients	1,830
Number maternal case visits	3,907
Number pupils inspected in schools	286,193
Number defects found	40,943
Number corrections made	6,048
Number pupils excluded	3,337
Number conferences with parents	3,447
Number lectures or talks given	454

In Illinois, the home hygiene nurses did a very splendid job. In coöperation with the State Nurses' Association, the visiting nurse associations and the Red Cross, this project employed more than one hundred nurses. It is estimated that fully ten thousand families were assisted from December 11 to February 15.

In Missouri, one of the outstanding services in which many nurses were given employment was the survey of crippled children, as a result of which 1,600 crippled children out of the 3,000 found in the survey, have received or are receiving hospital care.

California reports that exceptional interest was taken in the State-wide Child Health Study program in which 294 nurses were employed. Special study was made of three thousand children, and there is now a decided sentiment for a program to follow up the findings and recommendations of the nurses.

The report of the nursing projects from Georgia state emphatically that they were among the most satisfactory. The great need for all types of medical services was particularly felt during the winter months when there was an epi-

demic of measles, many cases resulting in pneumonia. This gave the nurses doing bedside nursing among these families on relief, actual opportunity to save lives that otherwise would have been lost.

Nurses who were correlating their services with the work of sanitary toilet construction and malarial drainage projects were able to show the contrast between the conditions in the communities having such services and those without them.

In one Georgia county, the Health Commissioner stated that the nurses had done more in health work in four months than had been done in years before. Physicians and prominent men and women throughout the State are enthusiastic over the work done. Counties in which nursing service has been discontinued are clamoring for its reinstatement.

In my own home state of Mississippi very splendid health projects have also been carried on. One is the teaching of home and personal hygiene, and the other is nutrition. There are 75 registered nurses teaching classes, stressing the importance of health in homes and communities; teaching how to be of service to the sick who are under the care of family physicians in the home; giving instructions on the control and elimination of communicable and other diseases. Also teaching prenatal care, the care of infants, preschool and school children, and teaching other simple health and nursing services every mother should know.

In Utah the Community Nursing Service under the CWA was the first Public Health Nursing Service to reach each county in the State. It was well received. All but one county seemed to feel that the condition of the children in many ways is better than before the depression. People are becoming "health minded." Of the 29 counties, 27 are fully organized and are conducting nutrition classes under the immediate direction of a county supervisor. There are 405 community leaders, teaching 465 classes. These classes are composed chiefly of mothers of families on relief together with mothers of young

children and of undernourished children. Over 10,000 people have been in these classes and have received home demonstrations since February 1, 1934. As a result of the nursing service many school districts are making plans to employ community nurses as soon as their tax funds will permit.

As a result of the Child Health Study Program supervised by State Health Departments with the coöperation of the Children's Bureau of the U. S. Department of Labor, 34 states and Puerto Rico definitely undertook state-wide child health nursing services and in several other states intensive child health work was done on a state-wide basis or through local activities. In this program, over 2,300 nurses were employed.*

LOOKING TOWARD THE FUTURE

Reports show that a good many nurses have been permanently employed as a result of the CWS projects. These projects have uncovered many needs that have long existed in the communities. It took a crisis like this to emphasize them. Nurses have aided greatly in improving the health conditions of the country during this period and it is my belief that when business conditions improve and more money is available through the regular tax channels in the states, many of the emergency services will become permanent services and the present problem of unemployment among nurses will then be solved to a very large degree.

Our Administration is giving two kinds of relief—direct relief for those who are not able to work and work relief to unemployed able-bodied men and women who want only a chance to work and earn. They want an opportunity to improve their recent standards of living. Work for pay is the curative power over the cause of need. But the problem goes even deeper than mere work. There are different means of providing for different people. President Roosevelt, outlining the ways in which the problems of relief were to be met with the \$950,000,000 appropriation, stated that there were three classi-

fications under which these problems fall:

First, the needy unemployed in urban centers who depend on wage jobs for their income.

Second, the needy families in rural areas who have not the means of making a livelihood from the soil.

Third, the stranded populations in places where industries have moved away or ceased to operate and where these people have been left without a chance of regaining their former employment.

Of course, direct relief will have to be continued to a great many families. There are now approximately 2,600,000 families on relief. There are many to whom the idea of being on relief is repugnant. The Federal Relief Administration does not want to force direct relief on these persons. Opportunity for work must be made for them. They will give service to the communities in return for benefits received, until they can find their place in commerce, in industry, in the professions.

In urban centers, towns and cities of 5,000 and more population (such centers are largely industrial) work divisions will provide and supervise employment projects. The persons who work on these projects will be those known to be in need of the work.

RURAL RELIEF PROBLEM

In rural areas the relief problem is vastly different. Families who have agricultural backgrounds have earned their livelihood from the soil and in many cases need only the aids that can be given them to make a large part of their own subsistence. They may need seed, tools, poultry, or some livestock, and the program now underway will provide these things. They will be given advice and assistance in rehabilitating themselves. This help will be supplemented by employment on public works that will give these families some cash income. The program of relief thus approaches the problem of families from a new angle and will form the basis of security for those of integrity, energy and thrift. In other words, this program for family relief will certainly help them to help themselves.

*See Dr. Martha Eliot's report, PUBLIC HEALTH NURSING, April, 1934.

The stranded families present still another problem. In some instances the entire populations of communities will be moved at their request and established in a section where they can help earn their living from the soil, while aiding in the establishment of small industries that will give them a cash income.

All three phases of this new program seek to point the way to self-support. The program offers a worthwhile goal toward which we all are striving—the end of the need for relief.

There will be no more mass relief, we believe, but rather a specialized, personal sort that will seek to aid the individual case. During the period of civil works the morale of many persons was strengthened. We do not want to lose this. The new program must not only meet the needs of relief but must aid in the building of courage, ambition, and a sense of security.

In rehabilitating families, the woman in the home—the home maker, the wife and mother, is the most important person. It is to this woman particularly that the women's work division will strive to render service. The program is in a very large measure educational. The woman in the home must not only have food, but she must be taught how to prepare it. She must be taught selection of food for proper diet. She must be taught child care, health habits, hygiene and sanitation. She must be trained and guided in all the ways of home-making in the truest sense of the word.

During April, the Federal Emergency Relief Administration has been endeavoring to find out how many families are really in need, and it is the intention of the administration, in coöperation with the states, to take care of every bona-fide unemployed needy person. This is not an easy task, and the transition from CWA to the new program is taking time for adjustment.

CONTINUED COOPERATION OF NURSES SOUGHT

What is done in the way of Work Division projects in each state is very largely up to the state administrations. I am sure it is the desire of each State Nurses' Association to continue to co-operate with the State Relief Administrations, and I hope that you will communicate with the Administrators and the Directors of Women's Work when you return to your homes, and tell them so. Through this continued coöperation they will be able to work out ways in which more nurses may be used in the program.

Selection of workers is made on the basis of need, determined by the Relief Administrations.

Determination of eligibility for relief of professional, technical, and skilled workers may be made in coöperation with professional and labor organizations. You can aid your needy unemployed by making investigations and certifying their needs to the relief administration. This is one very definite thing you may do for members of your profession.



Where Are We Going in Public Health Nursing and the N.O.P.H.N.?*

BY SOPHIE C. NELSON, R.N.

THE N.O.P.H.N. has become recognized as the body representing the unified thinking of our public health nurses individually and our nursing organizations collectively. We find public health nursing today playing a very conspicuous part in relation to the whole public health field. The N.O.P.H.N. has more definitely than at any other time been called upon to give advice and to act in behalf of public health nursing interests in relation to other voluntary, national, social, and health agencies as well as to our national official health agencies; namely, the Children's Bureau and the United States Public Health Service.

The N.O.P.H.N. has, as representing public health nursing, played an important part in relation to the numerous so-called emergency projects emanating from the Federal Government and affecting the use of public health nurses. Much time and effort have been spent in consultation with the F.E.R.A. on such projects as Rules and Regulations No. 7 and the C.W.A. and C.W.S. In Miss Tucker's report (see page 307), the details will be amplified. I merely want to point out that the increasing demand of our changing social order brings an increasing load to the N.O.P.H.N.

Old Man Depression did not depress the need but merely depressed the finances with which to meet those needs, and just as more and more burdens were being put on local communities and more difficult local adjustments were being made, so more and more burdens were being put on the N.O.P.H.N. Many curtailments were, of necessity, made in spite of the fact that more and more assistance and advice were being asked of the N.O.P.H.N. That was as it

should be because, if the N.O.P.H.N. is to fulfill its functions and its obligations as representing all public health nurses and nursing interests, it should, at this time, be called upon as never before. It has been impossible to meet all the needs that one would have liked because of decreased budget and staff. Our Committees and Sections have been called upon to give more intensive service than probably at any other instance in the history of the N.O.P.H.N.

NEW COMMITTEES

I should like to call attention to some new committees that have been appointed because they illustrate specifically some of the problems in which the N.O.P.H.N. must share and on which new emphasis must be placed.

As the problems have been more and more acute in relation to the employment, qualifications, and use of nurses through official channels because of their increased use in the emergency programs of the Federal Government, and because more nurses are likely to be placed under official jurisdiction in the forthcoming years, it has seemed advisable to focus our attention more pertinently on personnel practices in official health agencies, not only with relation to present but also future status. So, we have enlarged a Committee on Personnel Practices which will begin to make a study of personnel practices of official agencies in the United States.

We are particularly concerned at this time with the need of special emphasis in the maternity and child health field. As an aftermath of the interest aroused through the White House Conference on Child Health and Protection and the Child Health Recovery Program, it has seemed advisable to get specific advice

*Excerpts from Miss Nelson's presidential report at the N.O.P.H.N. business meeting, Biennial Convention, Washington, D. C., April 23, 1934.

in relation to where the focus in child health and maternity service should be placed, and so the Board of the N.O.P.H.N. has created a new Advisory Committee on Maternity and Child Health. This Committee has not, as yet, begun to function, but we know their activities will be very significant and far-reaching.

One of the most interesting of the things that has happened emphasizing the place of public health nursing, has been the formation of a Committee on Community Nursing Service. This Committee was formed at the instigation of the American Nurses' Association who, with us, have been feeling that there is need for developing better organization of local nursing which will be prepared to give and supply all types of nursing service to a community. The American Nurses' Association turned to us because of our interest and accomplishment in organizing community nursing services and asked us to take the initiative in forming a committee to study the problems and the possibility of community nursing bureaus. This Committee will consist of lay people and nurses interested in all phases of nursing activity, including nursing education, who are community-minded and think in terms of the whole rather than special interests.

OUR BOARD AND COMMITTEE MEMBERS

The participation of board and committee members and their activities in relation to the N.O.P.H.N. have been very striking during this depression. Other groups concerned only with a profession and the promotion of that profession have found themselves during these years in much more of a dilemma than we, and the answer would seem to be that much of our strength lies in the fact that we have taken into our confidence and have the confidence of the consumer, so to speak, and we have both appreciated the need of "jointness" in our thinking, in our planning, in our responsibility, and in our support. We are feeling the need, may I say, of more pertinent lay support just as we have been feeling the need of more professional support and as a result of our

thinking in this direction we are inaugurating on the first of May a definite effort to enlist wider lay enrollment in our national organization.

FINANCES

No report of what has transpired since the last Biennial would be complete without some comment from the President on our financial situation. A complete report for 1933 has appeared recently (see *PUBLIC HEALTH NURSING* for March, 1934) and a summary report of the two-year period appears on page 306 of this magazine, but I think it is important to emphasize again that just as in a local organization, so in a national—there have been an increase in demand and a decrease in income.

There has been an appreciable decrease in individual contributions and in our corporate membership dues. At our last convention, we reported the results of our nurse membership drive, and I am very happy to report that we have sustained an unusually high percentage of nurse members, which has been one of the bright spots in our financial situation. We have been equally pleased, in spite of the fact that there has been a considerable falling off, with the way in which public health nursing organizations have rallied to the support of the N.O.P.H.N. through corporate dues. It has indicated, we are sure, a real appreciation of the need of such an organization as the N.O.P.H.N., often probably at a sacrifice to local budgets. Large contributions have, of course, fallen off, and one of the problems facing the N.O.P.H.N., which the present situation has so clearly indicated, is how to make up for the loss of even one large contribution. We must work out ways and means of receiving new money, of getting many smaller contributions which will give us a firmer and more secure foundation as far as financial support is concerned.

I should like to reiterate the importance of a secure financial foundation for the N.O.P.H.N. and I should like to emphasize the fact that the N.O.P.H.N. is in a very precarious financial situation. Although we seem to have weathered the storm of the last few years very

well, our most difficult financial problems probably lie ahead of us because, due to several large losses in contributions, we are already having to use up the little balance which has accumulated over a period of years. (Our cash surplus now means only enough money to keep the organization going for a couple of months which we deem a necessary margin of safety.) It is important, consequently, that we be thinking of ways and means of making up our losses. It is also important for us all to realize that it is not simple to get money for a national organization. The emotional appeal is entirely lost, the activities seem very removed from the individual and the individual community, and these facts must be taken into consideration in all our financial planning.

APPRECIATION OF HELP

I should like to take this opportunity to thank all the members of our Committees and our Sections who have served so diligently and responded so magnificently to our emergency re-

quests. I should also like to say how appreciative we are of the response which we have received from individuals and from public health nursing organizations to requests for information necessary to the N.O.P.H.N. if we are to broadcast correct data as to the emergency situation. Those terrible things, questionnaires, have been true tests of your loyalty to the N.O.P.H.N.

Our Advisory Council has met with the Board on two occasions since the last meeting, and we wish to thank them for their assistance. We always feel that we are tremendously helped in our thinking by the reaction and advice of our Advisory Council.

The Convention is in effect the report of the activities of public health nursing through its central agency, the N.O.P.H.N., and I hope by the time the Convention is over that you will feel that the N.O.P.H.N., particularly the Board of Directors, has fulfilled its assumed obligation in safeguarding to the best of its ability the services which we believe essential to the maintenance of health.

EXCERPTS FROM THE TREASURER'S REPORT

During the last biennial period (1932-3) the income of the N.O.P.H.N. decreased from \$111,924 in 1932 to \$96,010 in 1933, a decrease of 14 per cent. Expenses, \$100,340 in 1932 and \$89,523 in 1933, decreased 11 per cent. The expense figure for 1933 is a reduction of \$23,321 under the 1931 expense. That is, in two years we have cut our expenditures, and of course our program, 21 per cent. In 1934, our income has been more seriously cut than in many years, due to the loss of certain large contributions. Fortunately, we can draw on a small balance of \$10,381, accumulated through the years, and we hope not to have to make further radical reductions this year, but we run on a reserve that can carry us for only two months.

With a decreasing income so that our margin of safety is correspondingly reduced, we must consider the future. On a percentage basis our sources of income for 1933 were as follows:

Corporate Membership Dues.....	16%
Individual Membership Dues.....	21%
Contributions	37%
Magazine Subscriptions and Advertising.....	20%
Reimbursements for Field Service.....	4%
Miscellaneous	2%

If the Organization is to continue to meet your needs in the coming years, the amounts represented by these percentages must increase from every source. Obviously we cannot continue with a reduction in income or expense such as was experienced in 1933—and still have an N.O.P.H.N.

Biennial Report of N.O.P.H.N. Activities*

BY KATHARINE TUCKER, R.N.

General Director

SINCE we last met, it has felt as if the whole world had been passing through a veritable revolution. While these conditions have brought serious losses in the world of public health nursing as in the larger world of industry, similarly much that it would have taken years to accomplish has taken place almost over night. An unescapable challenge calling for action not only to meet the present crisis but as a foundation for future development may be exceedingly painful while it is going on, but it puts new life, new imagination and renewed faith into the situation. No defeatist spirit has been abroad during these last two years in public health nursing because something could and must be done.

The N.O.P.H.N. has been in the midst of all this upheaval and revolution as far as they affected public health nursing. In fact, it is scarcely possible to separate the N.O.P.H.N. from the adjustments that have been made throughout the country. And the participation of this organization in them has been part and parcel of all of the activities of the staff. Furthermore, as at no other time in the history of social and health work, the workers have had the opportunity, particularly on a national basis, to influence the Government in some of its important projects.

Therefore, in presenting a necessarily abbreviated report of staff activities, the true picture of the significance of each activity can only be gained if the profound crises through which the country has been passing are considered as the background. Field trips, meetings, correspondence, interviews, the magazine, and even statistics—at times, especially statistics—have not meant that the staff has been busy as usual or that N.O.P.H.N. business has been as usual. Anything but! It has meant bringing

to bear on crisis after crisis all of the accumulated experience of the N.O.P.H.N. and its members and its committees, to assist and to give leadership in the working out of each particular situation whether for an individual, an agency, a state, the Federal Government, or the movement as a whole.

Certainly, these two years have been years of soul-searching for public health nursing. They have also been two years when the words change, adjustment, challenge, and appraisal have been sounded again and again and have not fallen on deaf ears. Our ears may at times have been very tired of hearing the sound of those words (and I wish we could invent other ones), and our spirits at times have been just a bit weary, but never, never dismayed.

Today I shall try to summarize what your National has been doing during this period through its whole program, and its service activities, which have actually revolved around those very words.

Once more as I did at the last Biennial, for simplification, I shall try to summarize under certain main headings, always reminding you that this is a purely mechanical device which leaves much to be desired because none of the activities of the N.O.P.H.N. is mutually exclusive.

WE HAVE "GONE NATIONAL"

If I were to summarize these activities in a phrase, I should say that during these past two years we have been primarily concerned with national planning. The N.O.P.H.N. might be said to have "gone national." All our action, all our thinking, all our considerations have been first on the basis of the country as a whole, then applying them to the local situation. This has been particularly true in our relationship with

*Presented at the opening business meeting of the N.O.P.H.N., Biennial Convention, Washington, D. C., April 23, 1934.

other national health and social agencies with whom we have been working more closely than ever. It really is quite thrilling to think that the American Public Health Association, the National Tuberculosis Association, the American Child Health Association, to name just a few of the health agencies, and the American Association of Social Workers, the Family Welfare Association, the Community Chests and Councils, to mention a few of the social agencies—that all of us together have been considering what is happening to public health nursing. We have all of us also been considering what has been happening in social work. And this means that in the national field as in the local field we do not and cannot stand alone.

This has meant that through our close relationship with these other national groups also concerned with national planning, we have interpreted what has been happening in public health nursing to them. Together we have been concerned how to protect public health nursing services in local communities. We have had the backing of these other nationals—and this has been translated for you down to your local situation. And I think you all agree—I know this from our correspondence and our field trips—that never have all health and social workers worked together so well as they have during this crisis, because they knew that only as they work together can they meet the situation and give an adequate community service.

After all, our problems are interrelated and certainly the solution is interdependent. Unemployment and inadequacy of relief and how they affect health and public health nursing programs; curtailment of funds and restriction of services—hazards common to the total social and health field—these are but illustrations of the jointness of our problems which have received national and local consideration. On questions of personnel policies, such as salaries, vacations, sick leave, we have presented a more or less united national front. Together we have been concerned about too great reduction in salaries and more recently with the possible restoration of salaries. The neces-

sity of adequate vacations and sick leaves has been generally accepted. The problem of selection of services has needed to be considered with the other national health agencies. The danger which I know you have felt, particularly in the rural field, of relief overshadowing the health program and the problem of the rural public health nurse when she is the only professional worker and is expected to carry the whole load for both the social and health program—there is no simple answer to these problems and they must be worked out with the national social agencies in the field. In other words, community planning in terms of community needs must be carried out on a national basis through the close association of national agencies representing the various aspects of the local situation. The N.O.P.H.N. has been your representative, increasing its strength to you through its contact with other nationals.

Also, there have been certain joint efforts in public education. In 1932 this was called the "United Education Program," by which we tried to carry on, on a national basis, a publicity campaign that would help protect our local social and health programs through successful financial campaigns. Last year this activity was called "Mobilization for Human Needs." We have here just another concrete illustration of national united action.

More particularly, as Miss Nelson has mentioned, we have had certain joint programs with financial participation from some of the national health agencies. The financial part has necessarily been less in the last two years. Our jointness, however, continues. And I think it is fair to say that all of the other national health agencies regard us as their consultants in public health nursing.

Another group that is also turning to us (don't be too hopeful, as this does not necessarily fill our coffers!) are the foundations. The Rockefeller Foundation, Milbank Foundation, Rosenwald Fund, and the Commonwealth Fund look to us for various types of advisory service. Also the Commonwealth Fund as you know gave us a most generous

contribution, \$25,000, to conduct a study of public health nursing throughout the United States.* But our relationship is more significant than just the question of whether we do or do not receive money. It means that these bodies that conduct research and demonstration in the whole field of health look to this National Organization for assistance in the field of public health nursing.

Needless to say, in terms of national planning, we have been most closely related to the American Nurses' Association and the National League of Nursing Education, and together we have conducted certain of our action in relation to the Federal Government. We have at headquarters what is (modestly) known as the "Cabinet." This Cabinet meets every week or every month as necessary. It consists of the executives and associate executives of the three national nursing organizations and the editors of the official journals, so you can be assured that we are thinking of nursing as a whole, each contributing from our own angle and assisting each other in our programs.

We also have relationships with non-professional national organizations, trying to get their interest and their concern in public health nursing down to their local groups. I refer to organizations such as the General Federation of Women's Clubs, the Association of Junior Leagues, the National League of Women Voters, the National Congress of Parents and Teachers, the National Committee on Volunteers. And I do not think we can minimize the advantage it is to have these powerful groups of women, some with very large memberships, concerned as citizens in their own community with what is happening in public health nursing.

TURNING TO THE FEDERAL GOVERNMENT

And then we turn (and I must say we have turned quite often during these last two years) to the Federal Government. Strikingly, there has been an opportunity for a mutually helpful interchange with various services within the Federal Government. First came the

N.R.A. and everybody wrote in to us and said, "Should we have a nursing code? Should public health nursing agencies sign the N.R.A.? What shall we do?" That was one of the times when the Cabinet had a meeting, since the other national nursing organizations were having that same problem. We decided that since we were a profession and not an industry we should not have a code. And in that the Federal Government concurred. We also decided, however, that to be in the spirit of the New Deal and the whole recovery program it would be desirable, if agencies wished to, to sign the N.R.A. as far as their non-professional staffs were concerned.

Next we come to what is known as the F.E.R.A. Rules No. 7. And I think you know, because we have not hidden our light under a bushel on this subject, that we were instrumental in getting the Federal Emergency Relief Administration to have nursing also considered as an essential to adequate care, in the document relating to medical care for those on relief. We also were instrumental in having it recognized that payment for adequate care for those on relief should be made to the agency best prepared to give that care (bedside nursing care), usually the private public health nursing agency. It is true that before Rules No. 7 got into action, the C.W.A. came along and almost swept this first ruling out of existence as far as nursing was concerned. However, I believe a very momentous thing happened even in the writing of nursing into Rules No. 7. We assisted in getting the principle accepted and having it written in, and we immediately sent it to our own constituency with interpretations and suggestions. Since that time we have been a sort of bureau of information and served in a liaison capacity between the F.E.R.A. and public health nursing throughout the country.

But what is of real significance—even though some of you have not had visits paid for from relief funds (because Rules No. 7 is permissive and not mandatory and your State or local Relief Administrator can prevent its

*See page 329.

being acted upon in your community)—is that it was recognized for the first time by the Federal Government that nursing care in the home is essential for an adequate relief program; second, that nursing in the home can be paid for from public relief funds—and by that I mean bedside nursing; and third, that payment from public funds to private agencies on a visit basis has been recognized. That had been done in a few communities before, but not recognized federally until now.

Another significance of Rules No. 7 was that the need and desirability of state nursing advisory committees were recognized, which means that professional standards should be safeguarded by the profession itself. That is quite an advance over some of our past situations when we have hardly been recognized as a professional group!

Finally we come to other letters in the alphabet, the C.W.A. and C.W.S., in which the N.O.P.H.N. also played a part, working constantly with the A.N.A. I want here to seize an opportunity to make a distinction between F.E.R.A. Rules No. 7 and C.W.A. as they affect nursing. The F.E.R.A. Rules No. 7 were written and administered to give better care to those who were on relief. C.W.A., which later became C.W.S., was to put nurses back into employment. That is a very important distinction. The C.W.A. since it was related to individual unemployed nurses was primarily the concern of the American Nurses' Association. Rules No. 7 related to community services and therefore primarily to the N.O.P.H.N.

However, the N.O.P.H.N. outlined the projects that were accepted federally as to ways in which C.W.A. nurses could be used in a public health program. But we do not hold ourselves responsible for all of the ways in which they have been used! Together with the A.N.A. we stated and tried to disseminate and promulgate three safeguards as to the use of this large number of unemployed nurses whom we were most anxious to have receive some help. The three safeguards were these:

That their professional qualifications should

be passed upon by a group representing the recognized nursing organizations

That they should be under adequate professional nursing supervision

That insofar as possible they should be attached to existing agencies.

And I might say that where those safeguards have been followed a very stunning job has been done throughout this land as far as the C.W.A. projects and public health nursing are concerned.

In addition, we have sent out a simple manual to those who were supervising public health nursing projects using C.W.A. nurses. We suggested a simplified record. We have widely distributed N.O.P.H.N. publications and a carefully selected bibliography to state relief directors, state departments of health, and all others concerned with nursing and C.W.A. projects.

Furthermore, we have had much closer relations with the United States Public Health Service and the Federal Children's Bureau than ever before. They, too, have used us in consultation in regard to their studies. They have used our published material. They have used our staff in consultation as to their specific objects related to the C.W.A. and the Child Health Recovery Program of the Children's Bureau.

In one more way we have gone federal and gone national. Probably you know that a National Re-employment Service has been organized with State Employment Services under it. When we heard about this, we at once got in touch with the head of the National Re-employment Service to let him know that we had published standards in public health nursing. He sent us the list of all the men who were in charge of the State Employment Services. To these we sent our publication on minimum qualifications. We certainly were very glad we had minimum qualifications to send them so they would know what was the nationally accepted standard of preparation for public health nurses in various kinds of jobs.

STUDIES AND RESEARCH

Let us now turn to our second main heading—Studies and Research. While that may not thrill you as a subject for consideration, it is basic for any kind of

a national service in order that we may help you, especially in times of change. You want to know what is happening in other parts of the country. It is too expensive for you to gather that material. Therefore we gather it for you. We want to know what is happening in order to guide us in our program and show us where leadership is needed. It really has been a coöperative undertaking as all of you know who have filled out questionnaires. We have asked you to give us the facts and we have tried to do the rest.

The actual statistical studies that have been carried on during these last two years can be summarized under two main headings:

First are the studies as to the immediate situation so as to get out to you just as fast as possible a report on what is happening. For this purpose we made a "Yearly Review" in 1932 and 1933. You know those prodigious questionnaires that you sigh over but greet with joy when the assembled material answers your questions.

We have analyzed information so we know what have been the income and expenditure in public health nursing during these two years of change.

We know which non-official agencies are getting tax funds for public health nursing services.

We know what have been the changes in administration, in program, in staff, in personnel policies, and in relations to other agencies.

We have been constantly asked for and have made special tabulations covering particular problems.

We made two yearly salary studies, and I cannot resist telling you that salaries are on the up grade—you will see the figures in the May magazine.

Special studies have been made on combinations of public health nursing services; on the relationship of the medical profession to public health nursing; and also a special study on relief-giving policies in public health nursing agencies.

In addition to these studies of current events, the N.O.P.H.N. has made two other—what might be called basic—

studies, more nearly in the field of research. And these have just been published. One is the Census carried on in 1931 but published this year, on the basis of which preliminary reports have been printed in the magazine. Now all the final tabulations are completed and ready for you in pamphlet form.* This material tells us the distribution of public health nurses—where they are and where they are not.

The second basic study is the survey of public health nursing paid for and published by the Commonwealth Fund** at a cost of \$25,000 to the Fund and \$2.00 to the purchaser. This is the first time that we have had anything like a cross-section picture of what public health nursing is today in the United States. This undertaking took two years to complete.

EDUCATION

Our third major heading relates to the N.O.P.H.N. as an educational organization. For many years, almost since there were graduate courses in public health nursing, this Organization has been concerned with them. During the last two years some member of the staff has had contact with every one of the endorsed courses in public health nursing in the United States. The Education Committee and the Council of Course Directors with the staff are constantly considering ways in which to make these courses more far-reaching in their influence on the adequate preparation of nurses for the public health field. Also the Committee is preparing to make a more careful study of the affiliation of schools of nursing with public health nursing agencies. What should the student nurse have had before and during such an affiliation to make it a truly educational process, and what are the assets and liabilities to all concerned in this joint project.

Schools of nursing through the League of Nursing Education and also through individual schools and state Leagues, are turning to us for this kind of assistance: "What kind of material should we have on social hygiene?" There is

*50 cents.

**See page 329.

a special committee with membership from the N.O.P.H.N. considering this question. "What should the students get in mental hygiene?" The New York State schools of nursing are considering this and consulting the N.O.P.H.N. "What public health material should be included in the curriculum and how?" is another question constantly asked—a problem jointly the concern of the N.O.P.H.N. and the League. Also there is a joint committee studying what material should be included in the curriculum that will give students an understanding of the social conditions that bring patients to the hospital and to which they return, this being inextricably bound up with questions of cause, prevention, and recovery.

As part of our own contribution to staff education, members of the staff have given twenty-three tuberculosis institutes; six on social hygiene; one state institute on supervision and two on general public health nursing. In addition, we have been working out a new device when we go to states, especially in connection with state meetings. These we think of as regional round table discussions (they can not be called institutes, as they are too informal). This device gives different groups of nurses an opportunity to present their problems for group discussion with a member from the N.O.P.H.N. staff acting as discussion-leader. There have been sixteen regional conferences of this type. For board and committee members, especially, twenty institutes have been conducted.

Needless to say part of our interest in public health nursing education and its ramifications, has been expressed through our participation in state, regional, local, and national meetings. And as heretofore I suggest that you consider this Biennial Convention as an educational device for all of us!

The magazine I have listed under one of our major educational activities because it seems to me it is in itself an educational institution. It is inextricably bound up with all public health nursing and with all that the N.O.P.H.N. is trying to accomplish. More particularly we have tried a plan

during these past two years of using editorials in the magazine as one major way of influencing public opinion and exerting leadership. Some guidance certainly has been called for with attention directed to the implications and relative values involved in questions of curtailment of services, administrative adjustments, restriction of salaries, and other problems relating to personnel policies such as vacations, sick leave. The N.O.P.H.N. has tried to stem the tide through these editorials, or at least to direct it into the most far-reaching sound channels.

The magazine has definitely been an even more obvious educational institution in the various study programs which it has published during this biennial period—three study programs for board member groups which seem to have been used by everybody, board members and public health nurses. Also we hear that social agencies have used the program on publicity and the one on general fundamentals of organization. The last study program which includes case studies has met with a very satisfactory response.

Our School Health Section in the magazine which we started in 1932, is now running a study program especially for school nurses. The social hygiene material that was published about a year ago seems to have had a very definite educational value for public health nursing agencies—several schools of nursing have reported using it.

"Listening In" has been used to serve somewhat the same purpose, although more chatty and informal than the magazine. Besides its being our most direct contact with our members, we hope it has given something which you can use in relation to your own service.

The educational tools that we published and reported on at the last Biennial Convention, which might be called guides to quality in content of program and performance, have been widely used during the last two years. I refer to the "Manual of Public Health Nursing," the statement of "Objectives," and the book on "Principles and Practices of Public Health Nursing," as well as the N.O.P.H.N. record forms. A revision

of all of our N.O.P.H.N. records has been completed and now we are working out statistical tools for agencies so that they will know the kinds of statistics that are essential for the agency and for comparative purposes. You see I am assuming that our publications have educational significance.

At last we have published a book on public health nursing in industry.* It is hoped that this book will be of value to nurses already in industry, to those entering the field, and also to industrial managers, showing them the potentialities in an industrial nursing service. The book was prepared by Mrs. Hodgson as a member of the staff of the N.O.P.H.N. and has been one of our major projects during the last two years.

Thinking of our educational program in terms of public education as well, note should be made of three national radio broadcasts.

N.O.P.H.N. material, publications, statistics, in fact all the information that we have, have been distributed at national and state groups. We have felt that it was a wise expenditure of money to see that our most important publications about what public health nursing is, our standards, the statement as to minimum qualifications of nurses, should be spread throughout the land. And we have tried to spread them. Particularly during the last two years, the N.O.P.H.N. has been generally accepted as a bureau of information in regard to public health nursing, as the spokesman, interpreter, representative, and standard-bearer of this special field.

DIRECT SERVICE TO MEMBERS

The last large grouping of N.O.P.H.N. activities is our direct services to members. This is a very imaginary distinction. All that I have reported up to date as to national planning, studies and research, and educational activities, are really direct services to you, though you may not be able to put them in a box and take a picture of them. However, there are aspects of the program that probably seem more direct. Members of the staff during these two years

have visited thirty-six states and two hundred and twelve places, again going from coast to coast and north to south. Obviously this record would be greater with a larger staff and larger budget.

Our advisory consultation service and direct service have also been through office interviews and letters. Never have we received so many air mail and special delivery letters, long distance telephone calls and telegrams. If anybody wanted to know anything, they wanted to know it quickly. A telegram would come from the Mid-West: "Our school nursing service is in jeopardy. The meeting is going to be the day after tomorrow. Will you send me by air mail the arguments I have to use with our City Council to preserve the school nursing service?" That is an actual example and I could give you dozens of others. This advisory consultation service by whatever means, whether a personal interview, in field trips or in correspondence, has simply reflected everything else we have been doing in national planning, studies, and in educational activities.

We have tried very definitely to assist agencies in the appraisal of their own services as these relate and measure up to community needs, and to help them in the necessary adjustments due to budgetary conditions. We have found that what has been wanted in this were judicious outside suggestions as to how to make an objective analysis of their problems and their opportunities; how to maintain a service on a productive level with decreasing income and yet to maintain good quality. You have wanted, specifically, advice as to adjustments in salaries, content of program, support, relationship between agencies; use of volunteers, sound methods of board organization, and personnel policies. You have wanted assistance in combining services and agencies, and certainly help has been needed as to how to use and be used in relation to various Federal and State projects. In all these connections field studies have also been wanted. State departments of health have turned to the N.O.P.H.N.

*"Public Health Nursing in Industry." The Macmillan Company. \$1.75.

more than ever before. Thinking of State departments of health and their public health nursing services as the keynote to the development of public health nursing in any state, any use that could be made of us by them we have considered one of the most important functions that we can carry out.

We have been concerned with both the preservation and promotion of public health nursing, how to keep it and extend it in any community; and how to start it in other communities and areas that have never had a public health nursing service. This has meant not only our own activities in public education but also very definite assistance in developing more adequate local publicity programs. Furthermore, we have worked out steps in organization for the community which needs to be stimulated and assisted in developing a new service where none exists.

I am not going to report on our activities in relation to vocational and placement services for individual nurses and agencies as this appears as a separate report (see page 326).

WHAT IS HAPPENING ON THE INSIDE?

Lastly, what has been happening internally to the N.O.P.H.N.? It is the same as what has been happening to you. Our income has decreased and of course our expenses have had to decrease correspondingly. At the same time demands and opportunities have grown apace. We have had to reduce our professional and clerical staffs. Economies have been the order of the day including salary cuts.

Also we have moved—not because it was cheaper to move than to pay rent, but because it was cheaper to move and pay *less* rent. And we now have less room.

In conclusion may I point out that I have not attempted to report on the activities of the N.O.P.H.N. in terms of special phases of the public health nursing program or in terms of special groups such as board members, school nurses, industrial nurses. These special reports as far as they concern groups will be heard at the Section meetings. While the N.O.P.H.N. does differentiate

so as to give service as needed and as funds allow, to any special group within the total field, the N.O.P.H.N. stands for the whole movement. Every member of the staff and every activity of the service has its relation to every phase including board members, school nurses, and industrial nurses. In other words, the N.O.P.H.N. is generalized rather than compartmented, just as a family, while made up of individuals, needs to be seen as a whole. Our planning, our studies, our educational activities, our direct services, have a relation to all those who are engaged in any aspect of the public health nursing field whether the administering agency is a department of health, a voluntary public health nursing association, a board of education, or an industry—or whether the workers are nurses, health officers, board and committee members, or volunteers. There is but one objective—how nationally and locally can the public health nurse be used to bring health most effectively to the families and individuals in this country.

We have been most fortunate in having very active committees which have represented both special groups concerned in public health nursing and special aspects of the public health nursing field. The Executive Committees of the Sections representing the groups, the Committee on Adjustments, the Education Committee, the Records Committee, the Committee on Field Studies and Administrative Practice, and the new Committee on Personnel Practices in Official Organizations—to mention but a few—illustrate those that have guided the N.O.P.H.N. and public health nursing in regard to special problems. In addition, of course, there have been the indispensable committees concerned with the N.O.P.H.N. itself such as the Organization Committee, the Magazine Committee, and the Membership Committees. It would have been impossible to have made such a report on the activities of the staff were those not constantly paralleled by committee consideration and advice. For the sake of brevity, we have not differentiated in this report in terms of committees and staff activities.

In this review we have been seeing what the N.O.P.H.N. has been doing. We have been involved in crucial issues of country-wide policy and in details of the programs and administration of local agencies. These two extremes not only have not been but could not be separated and throughout there has been a sense of participation in history-in-the-making.

Where possible, we have tried to "keep ahead of the tide" and to give some leadership to the adjustments which public health nursing must make to a changing order. It has been equally essential to bring some sort of stability into the situation. Therefore, emphasis has been laid on where public health nursing is now as a preparation for taking next steps.

THE FUTURE

For a moment in closing let us consider the significance of the future in public health nursing for the N.O.P.H.N. What seems to be needed?

Constant study of current developments, experimentation in planning and activities.

Constant education for all groups that

are concerned with public health nursing.

Emphasis on community needs and community nursing to meet those needs. Community nursing related to every phase of nursing.

A close relationship with all other organizations, professional and civic groups. Community planning for the whole social and health field.

And last, the extension and promotion of public health nursing into new health fields and untouched territory.

Public health nursing obviously is going through a crucial stage of development. Certain conditions can only be met locally. It would seem equally true that of all times, now and in the immediate future, the experience, thinking and perspective of others are necessary for planning and action, which meet not only the immediate crisis but form a sound basis for future activity. A national agency is the logical answer to this need of some centralizing of experience, thinking, leadership, and action. Here is national planning.

Dr. Winslow in a recent article in the *Survey* has said, "Nurses show the way." Let us continue to show the way together.

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IN MEMORIAM

The Advisory Council of the National Organization for Public Health Nursing has, during the last four months, lost three of its valued members—members who have given long service, shown unfailing assistance in the problems of our Organization, and who, because of their rare understanding of public health, will be greatly missed from our meetings.

Dr. Linsley Rudd Williams, whose death was recorded in our March number, had been a friend to the N.O.P.H.N. from its start; Mrs. Helen Hartley Jenkins, who died in April, was known by name to all our readers for her support and interest in developing the department of Nursing Education at Teachers College; and Dr. William Henry Welch of Johns Hopkins University (April 30th), whose fame as an educator and clinician was and is world-wide—for the loss of these three counsellors and friends of public health nursing the Board of Directors of the N.O.P.H.N. records its sorrow and its lasting appreciation of their services.

The Board has not as yet been able to appoint their successors.

HIGHER GOALS ARE SET BY CHANGES IN N.O.P.H.N. BY-LAWS

The revisions of the N.O.P.H.N. By-Laws as given in the March, 1934, number of PUBLIC HEALTH NURSING were unanimously adopted at the opening business meeting of the N.O.P.H.N. at the Biennial Convention.

A new goal is set through the provision for "Life Membership" available to any individual member upon payment of \$100 (payable within one year). It is with great pleasure that the N.O.P.H.N. announces that the first life membership goes to Emma E. Roberts, Superintendent, Toledo (Ohio) District Nurse Association. This membership is the gift of the Toledo staff to Miss Roberts as an expression of esteem and affection. It is over a year ago that the Toledo group suggested this type of membership to the N.O.P.H.N.

During the Biennial six life memberships were taken out, four by nurses and two by laymen. Life membership gives a splendid opportunity for conferring honor which many boards and staffs will wish to consider. It also appeals to those individuals who wish to be identified with the N.O.P.H.N. forever.

For nurse members, a new goal is set, in that beginning January 1, 1935, new nurse members of the N.O.P.H.N. must have graduated from a hospital having a daily average of fifty patients or more (the present requirement is thirty). It is therefore urgent that any nurses graduating from hospitals of less than a daily average of fifty patients join before January 1, 1935, in order to "get under the wire." The provision is not retroactive.

Other changes in the By-Laws were chiefly verbal changes—notably the dropping of the name "sustaining member" and the substitution of "lay member" until a better term can be found.



Report of N.O.P.H.N. Sections

SCHOOL NURSING SECTION

1932-1934

AS a result of the action taken at the last Convention the activities of the School Nursing Section have centered around two main objectives. You may recall that two years ago it was voted:

That the subcommittee on school nursing of the N.O.P.H.N. Education Committee continue to function as an education committee of the School Nursing Section

That a request be sent to the editor of PUBLIC HEALTH NURSING asking that a special section of the magazine be devoted to the interests of school nursing

This request was granted and the special section launched in October, 1932. The Education Committee then became by consent of its members an editorial committee for the special section of the magazine.

The personnel of the Education Committee consists of the following:

Ann Dickie Boyd	Beatrice Short
Vera Brooks	Mary Emma Smith
Dorothy Carter	Marie Swanson
Mary Ella Chayer	Anna Tittman
Katharine Faville	Dr. C. E. Turner
Hortense Hilbert	Mrs. Elmira Wickenden
Mary Hulsizer	

Ten meetings have been held during the biennium. Activities have centered around content to be included in the magazine and methods of securing articles and discussions from nurses in the field. During the second year, a study program was launched. In addition to the articles in the special section, various articles pertinent to school nursing have appeared in the body of the magazine in response to problems which have arisen in connection with economic crises.

One meeting held in May, 1933, was of particular significance in that attention was centered upon a critical review of the content and administration of school nursing in the light of recent studies which have been made by our national organizations. Dr. George T. Palmer led the discussion on general principles of administration. The following principles were enunciated:

"The health program of the schools should be definitely and fundamentally educational in nature and scope."

"The fundamental purpose of all health education is to equip the child with sufficient knowledge about health, favorable attitudes toward health, and worthy ideals of health to establish health habits that will lead to a more stable life, physically, mentally, and emotionally."

"While the promotion of health is one of the cardinal objectives of the school program, no service should be performed in such a manner that it takes away fundamental privileges or responsibilities of the home in relation to its children."

"Any policy that does for the individual what he can do for himself leaves him more dependent and less able and willing to care for himself when the protective hand is withdrawn."

"Those health services which are carried on in the community primarily for curative purposes should be administered and performed by some other agency than the school."

"The school authorities should provide only such professional personnel as can be justified on the basis of a necessary contribution to the educational program."

In the light of these changes, four major problems were emphasized:

1. *The nurse's program is too much a dispensary service.* Although it was recognized that a certain amount of treatment work was necessary, it should be capitalized as a device for instructing the teacher in recognizing symptoms and giving first aid in the nurse's absence. This same principle would also apply to the older children. Attention was also called to the meaning of "first aid" as a first and emergency treatment only. Specific policies in any given locality in relation to minimum treatment would be determined to some extent by the provisions of the local and state laws.

2. *Corrective work* (dental and tonsil clinics, etc.) administered by the school. Authorities feel at the present time that this should not be the function of the school.

3. *Confusion of fields of health, curative, and material relief* with the result that curative work is projected into what should be a preventive field. In localities where curative and relief facilities are lacking, the school should not be expected to supply the need but confine itself to the field of education for which it is responsible to the community.

4. With the exception of a few large communities, *adequate supervision of school nurses is notably lacking*. Of particular significance are the findings of field studies which reveal no distinction in quality of service, with or without supervision.

Where the nurse is largely responsible for determining the extent of her program, the following changes of emphasis were suggested:

Less emphasis upon correction of physical defects.

Appropriate emphasis upon communicable disease control.

Elimination of attendance officer duties.

Height and weight measurements to be used only as barometers of growth.

Instruction in balancing diets with special reference to reduced food allowances.

Less emphasis upon physical inspection, except where it is indicated by a specific condition.

Utilization of clinic services more as educational devices than as correctional devices.

Emphasis upon indirect teaching, rather than upon direct service.

Development of better rapport between teacher and nurse.

Increasing responsibility of the teacher for the supervision of the health of the child.

Development of parent conferences at school as a means of more productive utilization of time.

As a fitting sequel to these recommendations has come the report of the *Survey of Public Health Nursing* and its significance to school nursing. A discussion was presented by Hortense Hilbert of such import to school nurses that a Resolutions committee was appointed to take action upon the recommendations made in this report.

MARY ELLA CHAYER, *Chairman.*

At the luncheon and business meeting of the School Nursing Section on April 25 the following resolutions were presented by the Resolutions Committee:

1. *Resolved*, That we express to the PUBLIC HEALTH NURSING magazine an appreciation of the material on school nursing which has appeared in the magazine during the past two years.

2. *Resolved*, That we as a School Nursing Section accept the recommendations contained in the Survey Report and that we adopt measures designed to put them in force.

3. *Resolved*, That we request PUBLIC HEALTH NURSING to give us a series of articles to appear as soon as possible suggesting definite measures that may be taken to get these recommendations actually enforced in school situations.

4. *Resolved*, That committees of nurses now engaged in school nursing with experience in making successful visits of other types be appointed to work out material helpful in improving school nursing visits. This might take the form of a self-appraisal plan, an outline of content, or any other method approved by the committee.

5. *Resolved*, That a committee be appointed to outline administrative changes involved in incorporating these recommendations with various types of organizations doing school nursing work, such as provision for school nursing supervision in public health nursing organizations, lay committees for boards of education, enrichment of school nursing content in public health nursing courses, etc.

Dr. J. F. Rogers was the guest of honor at the luncheon and spoke briefly of the present trends in the school nursing program.

OFFICERS FOR THE NEXT BIENNIAL PERIOD

Chairman—Lula P. Dilworth, Trenton, N. J.

Vice-Chairman—Ella McNeil, Philadelphia, Pa.

Executive Committee—Nurse Members—Mrs. Ruth Carroll, Houston, Texas; Mellie Palmer, Des Moines, Ia.

Non-Nurse Member—Dr. J. F. Rogers, Washington, D. C.

Members holding over from last Biennial—Helen Hartley, Stockton, Cal.; Joanne Schwarte, Indianola, Miss.; Dr. C. E. Turner, Cambridge, Mass.

Report of the N.O.P.H.N. Industrial Nursing Section, 1932-1934

The report of the N.O.P.H.N. Industrial Nursing Section for the period 1932-34 puts forth for its greatest accomplishment the book, "Public Health Nursing in Industry." As the result of careful research in the various fields of industry and out of wide experience in public health work, Mrs. Hodgson's book, "Public Health Nursing in Industry," published by The Macmillan Company, left the press August, 1933. This book brings to the public health nurse the picture of a well-developed public health nursing program and plan and also shows her the relationship of the health of the individual to the family and to the community.

The N.O.P.H.N. has assisted in the formation of the Constitution and By-Laws of the Industrial Nurses' Club of Buffalo during the past year. At the business meeting of the Section in Washington, Dorothy Daniels from the Club gave a fine report of the Club, its activity and healthy growth from the beginning.

During the past two years the N.O.P.H.N. has assisted in arranging the program for the Industrial Nursing Section at the annual meeting of the National Safety Council in Washington, D. C., October, 1933, and at this Biennial Convention. Two papers were presented: "The Provisions Made by Industries for Medical and Material Relief for Their Employees" by Melda F. MacDonald, Salem, Mass.,* and "Mental Hygiene—Another Milestone in Industrial Nursing," by Heide Henriksen, Minneapolis, Minn. (See page 343.)

The papers and the discussions which followed showed that the industrial nurse is growing more conscious of her program as it relates to the community outside of her first-aid work within the plant.

The following change was made in the By-Laws of the Section:

Present By-Law:

Article III—Any member of the N.O.P.H.N. may become a member of this Section by sending her name to the Secretary of the Section for enrollment as a member.

Accepted Revision:

Article III—Any member of the N.O.P.H.N. interested in the work of the Section is eligible for membership in that Section and may become a member by checking the space opposite the name of the Section on the N.O.P.H.N. membership application blank or on the N.O.P.H.N. membership renewal blank.

OFFICERS ELECTED FOR 1934-1936

Chairman—Mrs. Elizabeth H. Emery, R.N., Yonkers, N. Y.

Vice-Chairman, Secretary—Joanna M. Johnson, R.N., Milwaukee, Wis.

Nurse Members

(Four-Year Term)

Mrs. Helen J. Macrae, R.N., Providence, R. I.
Nettie Amundsen, R.N., Milwaukee, Wis.

(Two-Year Term)

Adelaide Matthews, R.N., New York, N. Y.
Hilga S. Nelson, R.N., Newtonville, Mass.
Heide Henriksen, R.N., Minneapolis, Minn.

Honorary Life Member

Mrs. Marion T. Brockway, R.N., New York,
N. Y.

Lay Members

W. H. Cameron, Chicago, Ill.
Dr. William Alfred Sawyer, Rochester, N. Y.
James W. Towsen, New York, N. Y.
Mrs. Austin T. Levy, Harrisville, R. I.

*To be published at a later date in this magazine.



Board and Committee Members Section

FIVE YEAR REPORT*

ON September 1, 1929, a non-nurse staff member, Evelyn K. Davis, was appointed by the N.O.P.H.N. to work as secretary of the Board and Committee Members Section. The objectives of the program as outlined at that time were:

To unite board members in all parts of the country in a national group

To endeavor to bring about a better balance of responsibility between board members and nursing staffs

To assist board members in the solution of their common problems of administration by mutual exchange of ideas

To help board members keep in touch with the new developments in public health.

There was no definite program worked out in advance for the secretary, and as no other national agency had ever attempted such a development the N.O.P.H.N. had to build from the ground up and test tentative methods with care before their worth was evident. One of the first duties of Miss Davis, and one that proved to be a profitable experience, was to assist in the final writing of the "Board Members' Manual," which was first sold at the Biennial Convention in June, 1930.

FIELD WORK

The first year was spent in field work, acquainting board members and public health nurses with the new program. These informative trips have continued over the five years, during which 35 states and 199 places have been visited. After the first few months, invitations began to come from local groups, and in many places return trips have been made by request.

Various activities were carried on during these trips—talks were given to the board, to the staff, to a chamber of commerce, to women's clubs, P.T.A.'s,

Junior Leagues, and others. In some places institutes were held for all the board members of nearby visiting nurse associations, and lately, by request, many have been held for all board members of all the local welfare agencies. At these institutes discussions have covered the function of the board; organization of a board; functions of committees; duties of officers; the board's relationship to the staff, to the community, and the use of volunteers. A State Conference of Social Work asked Miss Davis to conduct a two-day institute, as a result of which she was asked to give the same material to a hospital board in another city and to the board members of all the agencies in a second city. As a result of another institute held for several visiting nurse association boards in neighboring towns, a vote was taken to make it a yearly meeting; a president of one of the boards present came into the office to discuss the complete reorganization of her board; and a new member of another board went to the next meeting of her board saying that now she had some idea of what was expected of her and what it was all about! In another city, where was held a general institute for all board members, one executive remarked that if it had not done one other thing, it had brought the board members together for the first time—something they had long hoped for. Various councils of social agencies sponsor these institutes. In one city the local Junior League invited the secretary to conduct an institute for all the Junior League members who were on boards.

Recent field trips have also included institutes at state meetings, institutes for public health nurses taking courses (see page 322), and advisory service to nine official rural services in the Southwest.

*Presented at the N.O.P.H.N. Board and Committee Members' Business Meeting, Biennial Convention, Washington, D. C., April 23, 1934.

BOARD ORGANIZATION

The "Board Members' Manual" has been interpreted to board members and a two-day consultation service has been requested by several boards. In these two days the secretary has helped to analyze the organization and membership of the board and shown the board how to use an outline in a self-analysis of their own.*

BOARD EDUCATION

Soon after Miss Davis started visiting local agencies, it became evident that many boards were not conscious of their objectives, did not know how to function smoothly, and were in considerable confusion over their relationships to the professional staff and their place in the community health program. In addition, almost nothing was being done to introduce the new board member to the work. Members of many years' standing frequently knew little about the public health nursing program. Often the board itself was too engrossed in its own work to recognize or have any knowledge of the other health work being carried on in the same community it was trying to serve. Some form of board education was plainly needed, and in addition to promoting the use of the "Board Members' Manual," an outline of suggestions for self-study was published in the magazine (see *THE PUBLIC HEALTH NURSE*, October, 1930). This outline was widely used, but proved a little difficult for boards to handle without the help from the secretary. Therefore a second program of study (see *PUBLIC HEALTH NURSING*, 1931-32) was prepared, breaking up the topics for study—one each for eight months, and adapting the questions to different types of services. In 1934 the two study programs were combined and re-issued, and some 463 agencies have requested this material to date.

The next study course was one on publicity. Since one of the most important functions of the board member is to interpret, there should be a good publicity program and it should be tied up very closely with the educational program, since, to interpret, one must

know. This publicity course was published in the magazine during 1932-3 and reprinted and sold to non-members for 75 cents. To date 148 copies of the whole set, which comprises eight lessons, have been distributed.

To give concrete help in publicity programs, loan folders of material were collected by Miss Davis and are available to local associations for cost of mailing. These are in almost constant use. They cover the following subjects:

Annual Reports
County Fairs and Window Exhibits
General Publicity Information
Movies
Plays and Pageants
Posters
Publicity Novelties
Radio

This year, a totally new approach toward education was tried. A course was outlined dealing with case studies. The secretary found that board members frequently knew little about the actual work of the public health nurse; they did not go into the homes, and the statistical reports given at board meetings of numbers of visits, etc., were ineffective in giving the board member an idea of the problems which the public health nurses meet in the field, the frequent inadequacy of community resources, and the relation of the nursing program to the whole health picture. Various agencies in the field coöperated with the N.O.P.H.N. in preparing this course by sending in outlines of actual cases. To date 123 copies of this case study have been distributed. It has been enthusiastically received by both board and staff members.**

All of these courses were worked out with the help of many other members of the N.O.P.H.N. staff.

Miss Davis has emphasized on every field trip, in every institute, in every conference with nurse and layman, this need for board education, and time and time again laymen have said, "That is just what we needed." Public health nurses have also been most appreciative of help in preparing their monthly reports and bringing to their attention the fact, of which they often lost sight,

*Outline available on request from the N.O.P.H.N.

**Copies available on request.

that the board member is not so familiar with the work as they are.

As a part of the board education program, the secretary has also assisted in collecting material and articles for the Board Members' Forum—now Page—in this magazine.

STATE LAY GROUPS

When Miss Davis started work, four state lay groups were formally organized so that board members came together with the public health nurses to discuss their mutual problems. These meetings were very beneficial to both groups and helped the board members get a perspective on their jobs. The secretary has assisted in developing state lay groups, and so far seventeen states have had state lay meetings and nine of these are now definitely organized. Assistance has been given to all these groups, and the secretary has attended their meetings and held institutes with twelve of them.

BIENNIAL CONVENTION

Since the inauguration of this N.O.P.H.N. program, greater interest has been shown by the board members in attending the Biennial Convention.* The planning of the program for board members and the suggesting of speakers has been the task of this section.

OFFICE INTERVIEWS AND CORRESPONDENCE

Board members have been writing and coming to the N.O.P.H.N. office more frequently of late. They come in with all kinds of requests—help on staff salaries, personnel problems of both board and staff, questions of membership, information on relief-giving policies, help with their constitutions and by-laws, medical advisory committees, development of a state lay group, use of volunteers, etc. The secretary does not herself answer questions dealing with a professional problem, but introduces the board member to one of the nurse members of the N.O.P.H.N. staff.

VOLUNTEERS

Contacts with the Junior League and other lay organizations showed an in-

creasing need for developing more and better volunteer jobs for public health nursing agencies. The economic situation, which depleted the professional staffs and threw economies into a place of foremost importance, brought to us the realization that some help must be offered to boards and committees in planning for the recruiting, use, and supervision of volunteers. Nothing proved more welcome to executives at this time. A questionnaire was sent out to a large, representative group of public health nursing agencies to discover how they were using volunteers. A complete report of the findings was published in *THE PUBLIC HEALTH NURSE*, January, 1931.

An article was also written giving a suggested plan for setting up a volunteer program, as Miss Davis found that when there was no carefully worked out plan, the volunteer service was unsuccessful. This article appeared in *PUBLIC HEALTH NURSING*, April, 1932. Also a training course for volunteers in public health nursing services was outlined and published in the *Junior League* magazine (October, 1929). On field visits the secretary has advised on how to set up a volunteer program and talked to the nurses about the use of volunteers. One agency reports that as a result of the secretary's visit it now has one hundred volunteers working regularly in the service.

ASSISTANCE TO PUBLIC HEALTH NURSES

At first the program was outlined primarily with the needs of the board members in mind, but the secretary soon found that leadership must frequently come from the public health nurses, and that, unless the nurses were convinced of the value of the lay group and knew how to use it, the board members' program was not of much value. Talks were given to public health nurses at state meetings; under the auspices of state departments of health; and lately, at the request of the course directors, conferences have been held with the graduate students in the public health nursing courses in Simmons College, Vanderbilt University, Teachers College,

*List of those attending to be published later.

Syracuse University, Western Reserve University, University of Minnesota, and the University of Michigan. In these discussions Miss Davis attempts to analyze the professional job as it relates to board organization, suggest ways of working with board members, of using volunteers, and discusses the general attitude toward lay participation in the program of public health nursing.

More and more public health nurses in official agencies have felt the need of lay committees, and the secretary has helped organize county committees, has conferred with health officers on the value of lay participation, and at the request of one health officer held a week's institute under a city health department. Among the official agencies the opportunities for service have only been touched on. There is a wide service yet to be rendered to them. In counties where the committees have been acting, they have, in several cases according to their reports, been able to prevent drastic cuts in the health budgets.

ASSISTANCE TO OTHER AGENCIES

Because other national organizations were not carrying on any definite program for lay groups, the secretary found herself being called constantly in consultation on programs for volunteers and board members. These contacts have been of great value: to the N.O.P.H.N. as a publicity medium; to the secretary to assist her in clarifying her job; to the local public health nursing groups in the recognition of the project by other national groups.

One of the first groups thus consulting the N.O.P.H.N. was the Association of Junior Leagues of America. The Association had appointed a trained social worker as field secretary at the same time as the N.O.P.H.N.'s project started. Miss Davis conferred with this new worker, and out of the contact has grown a very friendly relationship between the two national staffs. The field staff of the Association of Junior Leagues of America now numbers five, and they never go into the field without communicating with the N.O.P.H.N.

and finding out with whom to confer locally on matters of public health nursing. Often they have been most effective in recommending much needed changes and in assisting to bring up local health work to the standards recommended by the N.O.P.H.N. The secretary has been serving as the chairman of the Advisory Committee on Welfare of the Association of Junior Leagues of America, and has attended two of their conferences. Also at the request and expense of the Association, she participated in their National Convention in Los Angeles in 1932. These contacts have often enabled Miss Davis to bring the local Junior League more actively into the public health nursing picture, and in one agency it was possible to add some members to the board through her suggestion.

At the National Conference of Social Work in 1932, a committee was formed to interest laymen in attending the National Conference meetings, and Miss Davis was asked to be a member. At the 1933 Conference, she was elected chairman of the National Committee on Volunteers in Social Work and has been working on the program for laymen at the 1934 Conference. A greatly increased interest on both the part of the laymen and the social worker in this participation has been aroused. This committee has also been acting as a clearing house of information on volunteers and volunteer placement bureaus. The Community Chests and Councils have asked for assistance in formulating training courses for volunteers, a plan for a placement bureau, and an analysis of board organization as a follow-up on the Women's Crusade program. Some of the N.O.P.H.N. board members' material has been embodied in these training courses.

The Family Welfare Association of America is going to publish a pamphlet on volunteers, and has conferred with the secretary on this.

Several National agencies are developing training courses for lay leaders and there has been an informal group meeting at the National Y.W.C.A. to discuss methods, etc. Out of this is growing the need to make various

studies. One questionnaire used by the Y.M.C.A. was adapted by the secretary to gather information on the character of board meetings in public health nursing services.

In conclusion we feel that there is an awakened interest on the part of the board members in understanding what their job is and a more active and intelligent participation. We believe that we can say also that the public health nurses are much more active in using their boards; there is a better partnership between board and staff, and more

desire to meet constructively the needs of the community. There are still many states untouched and places unvisited and return visits should be made to many already developing special plans. Nevertheless we feel the experimental period of this board members' program of the N.O.P.H.N. is past and has proved its worth and we enter upon the next biennial period with confident assurance in developing the opportunities that lie ahead.

ANNE R. WINSLOW, *Chairman,
N.O.P.H.N. Board and Committee
Members' Section*

The Executive Committee of the Board and Committee Members Section of the N.O.P.H.N. for 1934-1936 is:

<i>Chairman:</i>	Mrs. Gammell Cross, Providence, R. I.
<i>Vice-Chairman:</i>	Mrs. Charles S. Brown, Jr., New York, N. Y.
<i>Directors:</i>	Mrs. G. d'Andelot Belin, Waverly, Pa.
	Mrs. Frederick S. Dellenbaugh, Boston, Mass.
	Mrs. Amos C. Sudler, Denver, Colo.
	Mrs. C.-E. A. Winslow, New Haven, Conn.
<i>Nurse Directors:</i>	Naomi Deutsch, R.N., San Francisco, Calif.
	Frances F. Hagar, R.N., Rutherford County, Tenn.
	Marion W. Sheahan, R.N., Albany, N. Y.



COUNCIL OF COURSE DIRECTORS AND EDUCATION COMMITTEE

Of the many sessions at the Biennial Convention on the education of the public health nurse, two of the liveliest were the all-day meeting of the Council of Course Directors the Saturday preceding the Convention, and the joint dinner meeting of the Council and the N.O.P.H.N. Education Committee. The discussions centered around the findings of the N.O.P.H.N. "Survey" and what public health nursing courses could do about the situation revealed in the Survey. The following questions that were asked and discussed at great length give the trends of the thinking of these two meetings:

Should it be the aim of the public health nursing course to prepare nurses for staff positions or for supervisory positions, or both?

If for staff positions, how can a larger proportion of nurses be reached for postgraduate study?

How can postgraduate preparation for supervisory positions be improved?

Are teaching centers necessary in a practice field in order to teach the content of public health nursing practice?

How can the courses better serve their local communities in stimulating staff education programs?

While cut-and-dried answers could not be given to all of these questions, the stimulation derived from the discussions and from the process of thinking them through together, will carry many of us a long way forward in our thinking and planning this coming year.

THE MEMBERSHIP RALLY

It was a real rally, when some five hundred members of the N.O.P.H.N. family gathered for luncheon in the Washington Hotel on Thursday, April 26.

"Honors" were the order of the day. We had as guests of honor Elnora E. Thomson, President of the American Nurses' Association, and once a staff member of the N.O.P.H.N.; Effie J. Taylor, President of the National League of Nursing Education; and Mrs. Chester C. Bolton, a member of the N.O.P.H.N. Board, and long a most devoted lay friend of the organization.

The honors were sung, yes, actually sung by Miss Nelson as she gaily made those clever introductions which were the hit of the convention.

Miss Mary Gardner, as Chairman of the National Membership Committee, came first. In her inimitable way, she made us all realize why she has for years come first in the hearts of N.O.P.H.N. members.

Her report of "Honors" in membership was too long to be told—it was revealed, however, as the intriguing yellow scrolls at each place were untied showing five pages of state by state reports listing those agencies whose nursing staffs are enrolled 100 per cent in the N.O.P.H.N. The scrolls also gave the names of each State Nurse Membership Representative and the number of individual members.

	1933	1934
Nurse	6,104	5,735
Lay	619	512
Total	6,723	6,247

Miss Gardner attributed this success in the face of the depression to the zeal and leadership of the State Membership Representatives who rose in a body to receive Miss Gardner's thanks and the applause of all the members.

As Miss Gardner paid tribute also to directors of local agencies, state organizations and national groups for their assistance, she exclaimed that "membership is the organization" and that future service in public health nursing will grow as we reach new goals in membership.

One of our new goals was then set up by Mrs. C.-E. A. Winslow, Chairman of the Board and Committee Members' Section, who made the announcement that during the month of May the N.O.P.H.N. is sending out a call for a nation-wide citizen enrollment. Since the N.O.P.H.N. stands first and foremost for community nursing service, the layman has a part in N.O.P.H.N. membership just as essential as that of the nurse. Mrs. Winslow pointed out that laymen form only one-tenth of our present membership. She challenged the nurses present to go home and encourage their board and committee members to join. She asked the laymen present to awaken the interest of other laymen. Together, nurses and lay members pledged their support to reach a new goal in lay enrollment for larger community service through the N.O.P.H.N.

The rally came to its climax in honors to the past presidents of the N.O.P.H.N. and to the past and present staff members. Messages from those who could not be present were read and greetings sent to them. Those responding to toasts as past presidents were Katharine Tucker, Elizabeth Fox, and Mrs. Anne L. Hansen.

The staff members were toasted by Anna L. Tittman as senior member of the present staff. Past staff members who attended were

Miriam Ames	Florence Patterson
Janet Geister	Ella Pensinger
Ruth Gilbert	Dorothy Rood
Melinka Herc	Beatrice Short
Mrs. Anna Behr Hollinshead	Marjory Stimson
Edna L. Moore	

The Membership Rally was a symbol of strength. It was a challenge, not to rest on our laurels, but to go forward for greater service in the future.

Biennial Report of the Joint Vocational Service, Inc.*

1932-33

JOINT Vocational Service presents its fourth report to the membership of the National Organization for Public Health Nursing. The first report was on one of initial organization and a year of experiment. The second, of progress in a going concern. The third was characterized by anxiety over the wide divergence between numbers of available workers and steadily declining opportunities for them. The present report is for a period that has called for constant adaptation, by changes of policy, to meet the emergent situation without sacrificing the standards of field or worker, the safeguarding of which we believe to be our chief function. We are glad indeed to be able to say that the outlook, based upon recent conditions, appears hopeful.

REGISTRATIONS, POSITIONS, PLACEMENTS

On December 31, 1933, we concluded our seventh year as a joint project with a record of 17,540 registrations handled, 13,981 positions handled, 4,549 placements made. There are now on file in our office more than 15,000 individual candidates' records.

For the biennium 1932 and 1933 there were 5,615 combined registrations in social work and public health nursing with a total of 2,826 positions for both fields, one-quarter of which were in public health nursing. Placements in relation to public health nursing positions handled were at the rate of 57.9 per cent for the biennium, and 59.4 per cent for the year 1933, the highest rate yet attained. More well qualified nurses were available, insecurity made them less particular in their choice of jobs, and a considerable number of positions filled were created by the emergency.

It may readily be seen that the preponderance of our work in the nursing field in the past two years has been in dealing with candidates rather than employers. The splendid spirit that nurses everywhere have shown in adjusting to a most difficult period has given us courage and inspiration. Often we found ourselves wholly inadequate to effect a placement where no job existed, but carried on correspondence and interviews with candidates with a view to strengthening their morale. One tangible form of help was our increased activity in informing large numbers of eligible candidates of forthcoming civil service examinations; also, in letting nurses know that they could have their records compiled and sent out without charge and upon request, to any prospective employer with whom they might negotiate independently of J.V.S. Vastly increased numbers of nurses have availed themselves of this service.

We have done our utmost to connect nurses with the various emergency programs. Constant interchange of information between J.V.S. and the N.O.P.H.N. has made this as effective as possible. A geographic file of registrants aided greatly in referral of candidates with specific locality claims. In one mail alone, 79 different records were sent of nurses who were registered with us as unemployed.

Toward the end of 1933, the situation began to look more hopeful in that while there was no increase in the number of openings, positions were more genuinely of a public health nursing type and appeared slightly more permanent in character. Quite recently the actual number of positions has increased and we hope this is an indication of a general upward trend, although it is too soon to make predictions.

*Presented at the N.O.P.H.N. business meeting at the Biennial Convention, Washington, D. C., April 23, 1934.

ORGANIZATION

Advisory Council: In April, 1932, an Advisory Council was formed under the leadership of Elwood Street. One hundred and twenty-one public health nurses and social workers from all sections of the country accepted membership on this council. These very busy people, at a time when they were harassed by local problems, have willingly undertaken to advise J.V.S. on local situations and to increase the number of positions reported to J.V.S. on the one hand; on the other, to interpret J.V.S. to local organizations and candidates.

Coöperative relationships: During the biennial period the relationships with affiliated and sponsoring organizations have been strengthened by joint conferences and periodic consultations between staffs. J.V.S. as the vocational service of the N.O.P.H.N. (more clearly defined than with other agencies) has functioned with increased facility through closer staff consultation and exchange of information and with the General Director of the N.O.P.H.N. serving as the President of the J.V.S. Board. Through the National Tuberculosis Association, and with the approval of the National League of Nursing Education, J.V.S. has extended its service to include placement of nurses in tuberculosis sanatoria. The value of tuberculosis experience in the equipment of public health nurses and the desirability that all nurses caring for the tuberculous should have at least a public health point of view are obvious.

STAFF

Budget difficulties made it necessary to reduce our professional and clerical staff. In September, 1932, the second vocational Secretary in public health nursing was released, but the position has not been dropped and will be filled again whenever the number of jobs reported and the income justify.

FINANCES

In 1932 it cost \$33,149.58 to run J.V.S. This expense was met almost in thirds each from three major sources: grants from Rockefeller and Russell Sage Foundations, \$10,900; fees paid by candidates placed \$10,747.76; subscriptions from organizations, \$10,018. Additional income from miscellaneous sources was \$668.57. The deficit of \$800 was underwritten by the Russell Sage Foundation.

In 1933 it cost \$38,626.27 to administer J.V.S. While income and expenses balanced at the end of the year an analysis of income is not encouraging. Income from foundation grants was just under 40 per cent (\$15,100). Fees paid by candidates placed yielded 30 per cent of the total cost. Income from organizations yielded only 25 per cent. The N.O.P.H.N., which makes an organization grant on behalf of the agencies in the public health nursing field, has subscribed \$4,000 annually during the entire existence of J.V.S., so the reduction from income from organizations in 1933 was in the social agency field. Again, the deficit of \$1,300 was met by the Russell Sage Foundation.

The problem which the board is now working on for 1934 is twofold, to increase income from what might be called earnings, that is, service payments from individuals and organizations, and putting into effect a plan for a more equitable distribution of cost between individuals and corporate groups.

COMMUNITY RESPONSIBILITY

Over a period of years local organizations had improved their personnel practice and with thoughtful consideration adopted many excellent policies in regard to working conditions. We had assumed that these policies had become an established custom but we reckoned incorrectly. Reduced income made serious inroads on most agency incomes. In some cases local boards planned so thoughtfully and were so steady and resourceful in the midst of panic that necessary reductions and adjustments were made without forsaking sound principles. In many other instances, unhappily, the progress of years in fair personnel practice was wiped out in a disorderly and precipitate retreat.

The development of sound personnel policies has its reason for being in the belief that fair working conditions produce better and more economical service for the community. If this theory is true, as we believe it is, much lost ground must be regained. We are pinning our faith on board member participation in the N.O.P.H.N. as an effective force to accomplish this in the public health nursing field. Only steady and consistent effort, resourcefulness and clear thinking on the part of boards and staffs conferring and working together, will bring back uniform fair practice in personnel matters.

ANNA L. TITTMAN, R.N.,
Vocational Secretary.

HIGH POINTS IN MISS GOODRICH'S MESSAGE*

"To the uninformed it would appear that 'periodic health examinations' were an accepted regimen of our 120,000,000 population. The number to whom such examinations are available is infinitesimal."

"The value of principles does not lie in their utterance any more than the value of knowledge lies in its possession. To the principles enunciated in the Children's Charter there would probably be nationwide subscription. Unless applied they have no significance. The possibility of their application depends upon an informed public. Address any group of well-informed citizens and ascertain the number who have given any thought to or even heard of this quite unique pronouncement."

"Which is of primary importance, to prepare a person for a given profession or for citizenship? Or, to put the question another way, which individual is likely to make the fullest professional contribution, one who feels citizenship to be the foundation upon which his professional practice rests, or one who considers his profession as an expression of his individuality?"

"Every school of nursing in this country within the next decade should be either definitely associated with higher education, and by that I mean a college or university, or discontinued."

"And lastly it is incumbent upon this now great organization of professional women to work unceasingly for the two essentials in achieving effective professional practice: First, within each given locality a centralization of nursing activities through which may be registered and met the nursing needs of the community in all its varied aspects. Such centralization, let me hasten to add needs more than a council of representative citizens and a well-organized bureau under a highly qualified director with a corps of assistants. It requires subsidy, local, state, and federal. We shall never meet the health needs of the people until we develop a program of support comprehensive enough to lift the burden of the cost of arising sickness and health conservation of every member of the population."

*"Changing Order and Nursing," Annie W. Goodrich—presented at the joint session, Biennial Convention, Washington, D. C., April 25, 1934, and published in full in the June number of the *American Journal of Nursing*.



The Survey of Public Health Nursing

The pivot on which much of the discussion and many of the new emphases turned at the Biennial Convention was the report of the "Survey of Public Health Nursing: Administration and Practice," carried on by the N.O.P.H.N. under the auspices of the Commonwealth Fund and published in book form* the week of the Convention. Katharine Tucker, General Director of the N.O.P.H.N., presented a summary of the *Survey* at the N.O.P.H.N. General Session, April 24, which was discussed by Katharine Faville and Elizabeth Fox. As the recommendations of the *Survey* are now available to all and as each recommendation is substantiated by the findings which every public health nurse will wish to study in detail, we are conserving space by printing here only the discussion of the recommendations.**

CHANNELS FOR IMPROVEMENT

*In Schools of Nursing and Postgraduate Courses*** by Katharine Faville, R.N., Associate Dean, School of Nursing, Western Reserve University:*

The report of the "Survey of Public Health Nursing" recently made by the N.O.P.H.N. draws a poor picture of the public health nurse as a teacher—that function which we have held as differentiating her from the private duty and institutional nurse. Many of us have long hoped that such a basis for differentiation will cease, that the word "nurse" will come to imply health teaching as well as the giving of care to the sick, and that our specialized names—public health, private duty, and institutional nurse—will refer only to our sphere of activity within or without the hospital walls. If this is to happen then what we say in regard to the education of the nurse so that she functions as a health teacher applies equally to the preparation of all nurses.

I have been asked to outline briefly what can be done by schools of nursing and postgraduate courses in public health nursing to improve the quality of the work of the graduate nurse in the public health field. Much has already been written on this subject, with which you are already familiar, and I will not attempt to summarize it. Since the study showed that only seven per cent of the nurses had completed work in an accredited postgraduate course in public health nursing, and that only one-third

had had theoretical work of any kind in the nature of scattered classes, it is obvious that improvement in the quality of work of the bulk of our nurses will come largely from two sources—the school of nursing and the staff education program of our public health nursing agencies. In considering the problem of improving the work of our schools of nursing, I would like to call your attention briefly to certain fundamental needs which exist at present.

THE SCHOOL OF NURSING

First: Control of the Schools by the Nursing Profession. Probably the most important question facing the nursing profession today is that of community planning for nursing education so that our poorest schools will be forced to close and our best allowed to continue. That this is not happening you can all bear witness from experience. Due to the facts brought to light by the Grading Committee, the better and more conscientious schools have in the main reduced their size, while the poorer schools have, in many communities, continued as before. This question of the control of the schools allowed to exist, thereby controlling quality, is at the very root of the problem of improvement of practice of the graduate—

*The Commonwealth Fund, 41 East 57th Street, New York, N. Y. \$2.00.

**See also page 336 in this number of the magazine.

***Presented at the N.O.P.H.N. General Session, Biennial Convention, Washington, D. C., April 24, 1934.

for there is only one gate of entry to the nursing profession—the school of nursing.

Second: Admissions to the Schools of Nursing. The quality of work done by any profession is governed to a very large extent by the quality of its intake. The last report of the Grading Committee calls attention to this in emphatic terms. It states that while most schools of nursing today require high school graduation, many girls are graduated from high schools who are not competent to go further in professional study. It recommends that applicants be selected from those high school graduates whose standing is distinctly better than that of the average of the class. The study shows that during the second grading but four per cent of the schools admitted only students above the average, and that twenty-five per cent of the schools did not even bother to gather this information.

Moreover, great care should be exercised to make sure that those retained as students have attained emotional maturity and stability as indicated by their social adjustments—for many intelligent nurses do very poor teaching because of immaturity or emotional difficulties. The exercise of careful selection at the beginning, and great discrimination in choice of those allowed to continue will be necessary before it is possible to improve to any great extent the quality of work done by our graduates.

Third: Improvement of the Quality of Work of the Graduate Staff. With the increasing employment of graduate nurses in hospitals the example which they set to students becomes an important educational factor. We talk to our students in the classroom about their obligation and opportunity to teach health while giving nursing care to patients and then we naively turn them loose into an environment where this practice is seldom observed. When does the student actually see the graduate at work teaching patients? In most instances this graduate is so crowded with work that she considers herself fortunate if she completes the ever-pressing load of administrative and nursing duties in

the time allotted her; and she rushes from task to task, setting an example in relative values which the student nurse unconsciously but rapidly imitates and adopts as her own. In many instances the graduate is herself the product of such poor selection and education that she is not equipped to teach. The last report of the Grading Committee showed that thirty-five per cent of the head nurse and assistant group are without complete high school education, and that fifty-six per cent more have had no study further than high school. No school can hope to turn out students who possess greater ability or vision than the faculty that teaches them, and any system of education which selects as teachers those who have no greater knowledge of content than that which is about to be taught, is a system from which little improvement can be expected. Therefore if the school of nursing is to improve the quality of its output, let it first improve the quality of its graduate staff.

Two factors are involved here—first, that of relieving the head nurse of many of her administrative, routine responsibilities so that she can have time to teach—patients, students, and graduates; second, that of helping her learn how and what to teach. A staff education program thus becomes an important step in the improvement of student work. Few such programs work well if superimposed from above; therefore, a committee of the staff should be appointed (with perhaps the community health nurse a member), organized to study how the teaching point of view can be introduced into the work of every nurse. Such a group would eventually develop a plan of study aimed to give the graduate staff a better understanding of the clinical material available on the wards, so that eventually the head nurse can emphasize in her teaching the underlying principles of good nursing rather than only the manual skills. Such a program of study would enable the group to answer such questions as these:

1. What opportunities does this service offer *me* to teach health—either by example, demonstration, or formal, group teaching—

to patients and members of patients' families?

- How can I, as a nurse, help to prevent a relapse in the recovery of this patient after discharge? Are there patients on this service to whose homes a visit by a public health nurse either before or after discharge would be helpful in preventing a recurrence of the diseased condition in the patient or his family?
- What is the relationship of the problem of this service to the public health and sanitation problems of this city? What sickness could have been avoided had the patient and his family possessed sufficient knowledge?
- What opportunity does this service offer to teach parents something of child care and training? How can parents develop an understanding of the progress made by children in the development of better habits while under hospital care, so that the child's routine will be carried out on return home?
- How are the problems of mental illness related to those of this service, and how can I develop a better understanding of the underlying implications of emotional to physical health?
- How can I make the student nurse aware of all the teaching opportunities and needs constantly presented on my ward? What does she need to know in order to make use of these opportunities? Where should it be taught, and how correlated?
- How can I work out a teaching program on my ward so that students see teaching done as a part of nursing, and learn by example as well as precept, that good nursing includes good teaching?

Fourth: Need for an Experimental Attitude. Nurses as a group are great imitators—we come to have fashions in nursing education as well as in clothes. Too few schools maintain an experimental attitude in striving to work out procedures best adapted to their own situation; and thus professional standardization becomes a professional handicap instead of a help. An example of this is the much talked of use of the out-patient department as the place in which to teach students to teach. Now your out-patient department may or may not be conducive to student learning and teaching—depending on the size of the staff employed there, the attitude of the doctors toward teaching nurses (which of necessity slows their work with patients considerably), the individual attention given patients, etc. In very few out-patient departments does the opportunity for teaching equal

that offered in a good public health nursing organization which is equipped to handle students. Therefore each school has to study its own situation, and decide just how and where the experience is best offered which they want their students to receive.

This brings up the consideration of the use of affiliations with public health nursing agencies and the present unsatisfactory relationship which is shown by the study to exist in many places. Every principal of a school of nursing where an affiliation is considered should know the standards set by the N.O.P.H.N. for such affiliations and should study the extent to which her school and the local agency are able to meet them. In many instances if the committee of the school of nursing and the board of directors of the public health nursing association would meet to talk the problem through together, a satisfactory adjustment undoubtedly could be made.

Fifth: Improvement of Teaching of Basic Content. At present in most of our schools the clinical experience is planned around the nursing needs of the hospital instead of trying to produce a graduate who meets the nursing needs of the community. Good teaching involves a sound knowledge of content, which most of our graduates do not have. If we could have coming to us in the public health nursing field, nurses who possessed sound fundamental knowledge of those services essential to community welfare, who knew how to give intelligent, skilled nursing care, and loved nursing, our work of making them teachers of health would be easy. But as it is, only about one-fourth of the group, or less in some states, have had experience in the nursing care of communicable disease (including tuberculosis, syphilis, and gonorrhea), and it is the rare nurse who has had good experience in psychiatric nursing, with a working knowledge of the relation of physical and mental illness to physical and mental health. That we need to emphasize normal function and development in our teaching much more than we do is shown by the graduate's lack of knowledge of the training, normal

growth, development, and behavior of children; and by her superficial knowledge of obstetrics—especially of adequate prenatal care.

In our enthusiasm to emphasize the rôle of the nurse as a teacher we have to remember that sound knowledge and understanding of content is necessary to secure sound teaching—that teaching is really an advanced nursing technique to be emphasized more and more as the student progresses in nursing experience and adds to content. While little in the way of teaching can be expected of the young student whose most important work at that stage of development is to learn nursing procedures, we can expect the older student and graduate to teach only in proportion as we in the schools have given her the proper knowledge of what to teach, and an opportunity to use this knowledge in teaching situations.

THE POSTGRADUATE COURSE

When we come to a consideration of the postgraduate course in public health nursing, the study shows the need of questioning certain practices. Only seven per cent of the nurses studied had completed work in an accredited course and only one-third had had theoretical work of any kind in the nature of scattered classes. Of the supervisors studied, eighty per cent came as field nurses to the agencies now employing them. Only one-fourth had completed a course, and only one-third had had theoretical class work of any sort. Obviously the supervisory group as a whole is poorly equipped for their great responsibility of guiding staff education programs and developing staff nurses.

Future Admissions to Courses. These statistics lead to a consideration of two possible policies in regard to future admissions to the courses. One would be to leave the preparation of staff nurses to the agencies, as at present; and for the courses to continue to affect only a small group (as they are now doing) but to select that group with the greatest care from among nurses who have had previous satisfactory supervised experience, changing the curriculum to fit students for positions as supervisors or as

nurses who will work alone. Emphasis would be placed on content and methods of supervision and of development of staff education programs, both introductory and continuous, and thus the courses would assist, *indirectly*, in the improvement of staff work by improving the quality of supervision. This change would necessitate complete reorganization of the present curriculum and to be effective would mean much closer coöperation from directors of health agencies so that promising staff nurses would be encouraged to apply for admission.

The other policy would be for the courses to make a definite effort to reach larger groups. With salaries as they have been and probably will be for some time to come, this will necessitate a material reduction in costs to the student.

The Education Committee of the N.O.P.H.N. might profitably study the location of courses in relation to the geographic distribution of public health nurses, and perhaps guide the development of new courses where they are actually needed. Elimination of a large travel item from the expense budget would help reduce costs. Also, if courses are located in centers where large groups of nurses are employed, it should be possible for them to secure their postgraduate study while working. The twenty-one months' program which Western Reserve University has opened to a selected group in coöperation with the Cleveland Visiting Nurse Association, and the development of part-time programs of work in Detroit (where over 300 locally employed staff nurses are going to school) and other places are examples of what can be done to reduce costs. It is not as important to the cause of good work that a few nurses complete the course each year, as that many are studying continuously and applying that knowledge to their daily work in the field.

Change of Emphasis in Field Practice: If, as the study shows, more and more public health nurses are to be employed by public agencies, then our courses should be doing all that they can to prepare nurses for those services most

commonly administered by the official group. This will mean in most instances a careful study of the present practice fields with an analysis of work available, and a consideration of how this work can be enlarged in scope as well as improved in quality. Of necessity in many of our courses the emphasis in the past has been on the morbidity service, but the time has come when emphasis will have to shift. Very few courses are offering a well-rounded experience in communicable disease nursing from the angle of both the public and private agency. Almost none are offering work of practical value in the control of syphilis and gonorrhea; and few are giving their students a sound fundamental knowledge of tuberculosis nursing, especially as the problem is found in the rural field (an entirely different situation from that of a large city where most active cases are hospitalized). Again, our field experience in school nursing is very weak—lasting usually so short a time as to be merely routine and observation—with little consideration of the technique of developing valuable relationships with parents and the school group. In this service we are often at a disadvantage in that we have less control of our practice field, but certainly much more can be done to develop the content of home visits to school children.

In short, courses have been fairly successful in teaching the nursing care involved in the morbidity service; we need now to strengthen the field outside this service. In some instances this may involve control of the practice field by the school instead of maintaining an affiliation with a local coöperating agency. It will certainly necessitate a staff education program planned to improve the work of the permanent staff employed in the practice field.

Improvement of Teaching. Many of the difficulties described in the study seem due to a lack of a clear understanding of the difference between means and ends—a lack of development of a good sense of relative values by the nurse.

May not one reason for good technique and poor teaching be due to the

fact that in our field work there is a tendency to place such great emphasis on mastery of technique that the student comes to value it beyond all proportion—seeing it not as a means but as an end in itself? Like all teaching our introduction to the field needs constant emphasis on the underlying reasons for all that we do, and our supervision needs to stress less the importance of letter perfect technique, and more the use of nursing procedures as teaching tools. Time needs to be spent helping students analyze the quality of their teaching, to study family and individual differences, to study their successes and failures in order to try to determine for themselves whether failures are due to poor method or lack of knowledge of content, with the hope that eventually we will produce nurses who possess the power of self-analysis and self-direction, and who consider it a part of their work to be their own severest critics.

The staff nurse is feeling an increasing demand for group teaching; which, if it is to be a recognized part of her work in the future, must be planned for her as a part of her student field experience. This means that we will have to provide opportunity for her to teach—not a class or two—but a series long enough so that she develops self-confidence and learns to study her own improvement, a program which necessitates the most careful sort of supervision.

RECORDS AS TEACHING DEVICES

All through our work we need greater emphasis on the underlying reasons for what we teach, rather than stressing methods of work. This is illustrated by the findings of the study that nurses do not use their records—they merely keep them. Of course we have to admit that some health agencies are asking nurses to keep records which contain so many items that, with the pressure of work, they can neither be kept nor used intelligently; and one way to cut administrative costs would be for such agencies to simplify their nursing records, being very sure that every item kept is actually used. Nurses and especially super-

visors need a better understanding of the use of statistics, of the value of records as lesson plans in family teaching, of the need for developing programs of work from actual facts relating to their services gathered from their records. Too many nurses fill in records today to oblige their supervisors; too few because they feel them to be indispensable tools to better work.

When it comes to the teaching of relationships—with the medical profession, with other social and health agencies, with lay groups and board members—probably students will learn these best through seeing them functioning successfully in the field program and actively participating in co-operative relationships in specific situations. Therefore, our courses would do well to review their own practice in such matters—to see in how far it conforms with their classroom theory; and to study to what extent emphasis is spent on developing a clear understanding of underlying reasons for such practice.

Now this type of teaching with emphasis on principles rather than on methods takes time. With much of the present postgraduate course given over to patching up poor basic training, the time left for work of a really post-graduate nature is far too short. If we are to improve the quality of work done by our students one of two practices will have to be adopted—either the length of time spent in the practice field will have to be increased (some courses have lengthened the time devoted to theory, but few have increased field time); or we will have to admit to our courses only those with adequate basic education (which will eliminate the majority of the present graduates who apply). The first will increase the cost to the student unless arrangements can be made for co-operative programs with local public health nursing agencies; the latter will necessitate much better co-operation with directors of public health nursing agencies, so that their best staff nurses will be encouraged to take further study.

Just how, in the future, the courses

are to be developed to serve the profession best is a question in which administrators and supervisors of public health nursing agencies must show an active and intelligent interest. Valuable support has long been given by some of our nursing leaders who consistently make further study possible for their promising staff members through personal encouragement, scholarships, leaves of absence, etc. We have, however, many large agencies where neither staff nor supervisors receive the slightest encouragement (it is interesting to note that only four agencies in the study had scholarships available to staff nurses)—and much more co-operation will have to be shown by these directors, if the courses are to be utilized to their maximum in improving the quality of field practice, whether through work with the small supervisory or large staff groups.

COMMUNITY PLANNING

In the last analysis, underlying all our problems is that of community planning—of all nursing agencies working together in the community for the good of that community rather than for the good of individual agencies or groups. This involves planning for nursing in all its phases on a community basis so that good schools are not allowed to close and poor ones to continue; so that quality of intake into the profession is controlled; and that improvement is developed in the relationships of nursing to the medical profession and social agencies, in standards of personnel, in programs of staff education, of supervision, of participation of lay groups. Do we not need to emphasize in both nursing education and practice, more of the philosophy underlying all professional work so that instead of producing merely skilled technicians, whose loyalties are confined to individual patients and agencies, we develop nurses with a vision of their obligation to work for the common good—and who possess ability to think in such larger terms of unselfish service that their vision ultimately becomes their practice?

CHANNELS FOR IMPROVEMENT

(Continued)

Through Public Health Nursing Agencies by Elizabeth G. Fox, Director, Visiting Nurse Association, New Haven, Conn.:

I want to suggest five of the more important ways in which public health nursing agencies can improve the situation disclosed in the *Survey*.

First of all, we must go to the root of the matter, which is the fundamental education of the nurse. It is always costly and often impossible to make a good public health nurse out of a poorly trained nurse. The great majority of nurses who apply to us have not had a real education in nursing and do not possess even the ground work for public health nursing. It is time we public health nurses stopped complaining and joined hands with the National and State Leagues of Nursing Education and Boards of Nurse Examiners in their battle to develop more good schools and eliminate the poor ones. In this battle, our boards of directors could exert a powerful influence if they would.

The *Survey* shows that we are weakest in the very thing which should be the essence of public health nursing—our teaching of our families. This is not to be wondered at in view of our comparatively poor undergraduate preparation in the biological, physiological, and social sciences, to say nothing of mental hygiene. We can make up for this lack of scientific content and knowledge of teaching method and of human nature only by taking staff education much more seriously, devoting more staff time, more agency money, and far more thought to the continuous training of our staff. This is costly, but not to do so is more costly, for without such study we throw away our time on visits which have little body.

We must reduce case loads. It is futile to expect thorough and finished work on a family basis achievable only by patient teaching when the nurse is carrying so large a case load that it is often weeks or months between visits. The two things are not compatible. A selection of our cases based on a study of conditions leading to success or failure might show us some points at which failure is inevitable and therefore at which reduction can be made without harm. Beyond that point we must either increase our staff or be ruthless in limiting our intake, unless we are to remain content with superficial work.

So long as we must train our staff to be public health nurses on the job we need more supervision and supervision in the modern conception of that term. We must convert our boards, and more especially our public officials, to an understanding of the true function and value of supervision and a realization that it is not economy but rank wastefulness to have so few supervisors as many agencies have today. It is not only an increase in number of supervisors, but a change in our own attitude toward supervision that we need. We used to think supervision was getting things done; now we know it is helping our staffs to grow. Few of us know how to supervise in this way and there is crying need for us to learn.

It is at this point that a psychiatric social worker on the supervisory staff is of incalculable help, for good supervision is based on a far clearer understanding of human nature, our own and others, than most of us possess.

The *Survey* shows also that we executives, most of us having come up from the ranks, including the writer, know very little really about this business of administration. Attempts to analyze our work statistically and from an accounting angle make our heads ache. We must take advantage of every means available to learn how to appraise what we are doing in terms both of results and costs.

The *Survey* would be discouraging to me if I were not so sure through experience, that when staff nurses are given a chance through better fundamental education, better staff education, better supervision in the sense of helping them to grow, lighter case loads and better administration, they can and will measure up. Public health nursing can be the thing we want it to be. All that is necessary is to see what are the obstacles in our path—and the *Survey* shows us clearly what they are—and then have the energy and will to tackle their removal.

The Board Members and the Survey of Public Health Nursing *

By ELMIRA BEARS WICKENDEN

Board Member, Public Health Nursing Organization, Eastchester, N. Y.

THE nursing profession has an outstanding characteristic of which it has reason to be proud, and that is the courage to study and analyze its activities and to keep informed regarding the soundness and success of its present methods as well as its future potentialities. Public health nurses have had considerable responsibility for stimulating and participating in these studies. It is possible that board and committee members by their encouragement and ready coöperation have contributed largely to their success. These surveys cannot be undertaken without the help of local agencies which are willing to submit their programs and methods of procedure to the searching analysis of the impersonal and unrelenting surveyor. Because of this willingness to join with the professional group in an effort to ascertain the present status of our progress and objectives, we are equally concerned with the results. That the study revealed a somewhat discouraging picture is all the more reason for our attention being directed to those recommendations for improvement which concern us primarily.

I am going to quote from the introductory paragraph of Chapter II on Conclusions and Recommendations of the Survey:**

"This survey gives significant information as to present-day status of public health nursing in its major aspects: organization, administration, nursing program, and performance of the nursing personnel. From this information certain conclusions can be drawn as to the extent to which public health nursing agencies of different types have accepted and have translated into practice the generally recognized principles, objectives and criteria developed and set forth in various publications.

*Presented before the N.O.P.H.N. Round Table for Board and Committee Members, Biennial Convention, Washington, D. C., April 24, 1934.

***Survey of Public Health Nursing: Administration and Practice.* The Commonwealth Fund, 41 East 57th Street, New York, N. Y. \$2.00.

Also it is possible to point out certain tangible results of these practices on the basis of an analysis of the work of their nurses in the field. Material, therefore, is provided upon which major conclusions can be drawn as to the present status of public health nursing. It should be made clear, however, that . . . any statement of objectives or any accepted criteria should not be final or static. In any dynamic field these grow and change continually. Furthermore, what are goals for some are points of departure for others. Nevertheless a study of any activity, at a given moment, must take as a base the criteria most universally accepted at that moment."

It seems to me that we may divide the recommendations into two groups: those that can be carried out only through our own enlightened intelligence and efforts, and those about which we should be informed in order to support the professional staff in following them to achievement.

AS FEW AGENCIES AS POSSIBLE

The first group is concerned largely with organization, and, to a lesser degree, administration. It is important that we study at our leisure those relating to nursing program and performance, but the leadership for these last two aspects of the situation must come from the staff, which in turn has a right to expect understanding of these problems from a well-informed board.

The first recommendation is:

"Since the goal in public health nursing, as in any service essential to the well-being of the population as a whole is a comprehensive community program, the committee strongly recommends that all public health nursing services be carried by as few agencies as possible. Through a combination of agencies, as is self-evident and has already been demonstrated, a service of more uniformly high quality can be rendered in a community with

provision for a more effective program of supervision and staff education, with less expenditure of money, than when there are several independent services. The survey shows beyond the shadow of doubt that such provision is one of the greatest needs at the present moment. Whatever may ultimately be the accepted responsibility of the government for providing essential services for its citizens, in the immediate future it would seem possible to accept in the majority of instances the standard of not more than two agencies administering public health nursing, one official and one privately financed and administered."

The committee also suggests further experiments in developing a service under a single agency such as exists in small communities and rural areas.

This recommendation concerns us as citizens as well as board members. The real reason that this first challenge is one of the hardest to meet lies deeper than just lack of knowledge of economic and efficient administration, which we might be excused from understanding until our interest has been aroused by participation in the work through membership on a board. The responsibility for retarding this progressive step rests squarely upon our unwillingness to break with traditions. We like our own little show; we distrust for good reasons the integrity and sincerity of our politically appointed public officials; we find it contrary to established procedure to charge the individual for services that are supported by taxation; we know that there are limitations to the use of public moneys that prevent expansion of program and experimentation. These are the real reasons for our reluctance to effect combinations of agencies and to eliminate duplication of services. Yet these obstacles have been overcome when the community's well-being has been placed ahead of each agency's particular interests; where personnel of highest qualifications have replaced politically appointed and untrained officials because the citizens demanded it; and where the service can be made at least partially self-supporting because an effort is made to sell the service to those able to pay something for it, regardless of their economic status, thus making available the service to all economic levels.

Official, or tax-supported clinics, and out-patient department services may charge for their services and the same procedure can be inaugurated for public health nursing service. The chief obstacle we need to overcome, if we really desire to give the community the most comprehensive service for the least money, is change in our present philosophy. Whether it be under official administration, supported by a combination of tax funds, fees for service rendered, and private subsidy, or for a private administration, subsidized to some extent by tax funds, the goal we must work toward consciously and free from all traditional prejudice, is one administration of the public health nursing work of the community or as a compromise to still-existing obstacles to progress, two administrations, one public and one private. If we do not think and work in this direction the trends of the day will influence official control before we are ready for it. Our economic situation and a changed attitude about official responsibilities may force us to do something about this weak spot in our program, the solution to which we have evaded for years. If we do not have a plan ready, people far less informed than we are will be controlling the scope and objectives of our public health work. We already know that private funds will decrease when taxes are increased and communities supporting two or more private agencies with similar services should be foresighted enough to combine under one private administration as a first step, before they are condemned by public opinion for an unjustifiable expenditure of money that is raised by heroic efforts. Those of us who live in cities or towns where more than two agencies administer public health nursing need to accept this problem as our own and to study and plan for a satisfactory local solution while we still have time.

LAY ADVISORY COMMITTEES

Recommendation No. II deals with organization of boards and committees, which is subdivided into two definite parts. Part one reads:

"The Survey Committee wishes to point out that the general trend in community organization would seem to indicate the desirability of a lay advisory committee which would be concerned with the whole health program, backing and interpreting it both to the citizens of the community and those officially responsible for financial appropriations. On such a committee might well be represented one or more persons who have special interest in and knowledge of public health nursing. Further, if the need was indicated there might be a small group of persons who would serve as consultants in relation to the development of certain professional aspects of the public health nursing program. These groups might have geographical or functional interests. These small groups might develop into the general representative advisory committee. Experimentation is recommended along these lines."

When we realize that public health nursing in health departments seldom, and in boards of education almost never, has the benefit of the thinking and support of lay advisory groups, we can turn to an almost untouched field of work in interesting our local health and education departments in using such groups. Here is work at our hand if we care to do it, and a constructive first step for any group which is considering the combination of services.

While boards and committees having administrative as well as advisory status are almost universal in privately financed agencies, we have established certain unfortunate habits that could be improved upon.

The second part of the general recommendations for board and committee organization relates to broader representation on our boards of community interests and to the inclusion of men, the rotation of membership and the restriction of terms of office.

Acceptance of these recommendations will result in broader vision and usefulness and in elimination of static control. Very few boards of privately administered public health nursing agencies have not faced these problems, adding to them the one of irregularity of attendance and consequent loss of continuity of interest on the part of the individual members. In some instances we honestly believe that a narrow circle, representing a socially prominent and influential group, can work most effectively because they accomplish most in

raising funds. When we convince ourselves of this we overlook the more important consideration of community education. Raising money to carry on the work is essential but there are better ways of doing it than depending upon a small group. Only through representation of the various social and health, geographical and even religious interests, can we become aware of the equally varied points of view, and can we in turn interpret our program to all phases of the community life. Universal support, both financial and moral, would seem to be the only sound basis for growth or adequate budget.

MEN AS BOARD MEMBERS

In other instances we hold to the theory that women make better board members than men. From the point of view of leisure time and need for an absorbing interest, this is doubtless true. But what other good reasons can we put forward for this attitude? The extent to which men may participate in committee work depends largely upon the type of community in which they live. If their business is located in the same community, they often find time to attend important meetings, and their limitations of time for such meetings can well prove to be an advantage if it encourages better preparation for the meetings and more business-like disposal of the business on hand. In suburban areas where business and professional duties take the men to a neighboring city, it is true that the bulk of the committee activities must be carried by women. This should not be given as a reason, in my opinion, for debarring men from membership on boards where their more detached point of view, their more detailed knowledge of business methods, and their conversion to the cause, are all badly needed. Evening board meetings and certain types of committee meetings are just as well attended and just as productive of good results as day-time meetings.

The Survey findings show, however, that only a fraction over half of the agencies studied include men as members of the board and that less than a third show any interest in obtaining

geographical, religious, or related activities representation. It is true that our present type of organization is often a conscious compromise between the outgrown past and a hoped-for future. It is also true that experimentation along the broader lines of these recommendations points out the need for evolving slowly and in ways best suited to the particular and sometimes peculiar community. The essential thing is to be aware of better methods of organization and to work toward them with modifications which suit individual communities.

ROTATION OF MEMBERS

The same good intentions hold good for rotation of membership and limitation of office. If we can find only one good and efficient set of officers it is because something has been wrong with the selection of the board members. Such a condition is much more apt to exist in the static board. Any excuse we offer for long tenure of service on the board or as an officer reflects upon our judgment in selection, and the continuance of these habits deprives the community of its proper responsibilities and of an expanding program.

Proper recognition of the principles underlying these recommendations provides another step forward in advancing Recommendation No. I.

It is also of interest that the Survey revealed considerable disparity in the set-up of committees of non-official boards. Two of the twenty-one private agencies studied did not have printed constitutions and three were not incorporated according to the state laws. Of the three essential committees, nursing, finance and medical advisory, the finance was most often missing.

RELATIONSHIP OF NURSE DIRECTOR

It was found, concerning the relationship between nurse director and governing board, that certain established rules of procedure are followed pretty generally in privately supported agencies. A clear division of responsibility between them is observed. The nurse director is appointed by the governing board in every instance, and in all but

one she appoints the nursing personnel, with the approval of the board. Since she is responsible for the nursing program and the quality of the work, she needs also to be responsible for the selection of a staff well qualified according to professional requirements.

In all but one organization studied the nurse executive participates to some extent in the meetings of the board. It seems to go without saying that her attendance should be—

"... necessary for mutual familiarity with point of view and for coördinated action on administration policies. On the other hand she can hardly be expected to translate policies determined by the board into the nursing program and practice intelligently and effectively if she is not kept in constant touch with the policy-making body, while on the other the board cannot determine policies wisely and fairly unless its members are kept constantly aware of public health nursing objectives and methods. The executive needs to keep board members informed of staff needs, of changing needs in the program and of advanced procedures and techniques in the field of public health nursing."

It is heartening to know that this relationship is almost universally accepted and practiced.

RELATION TO THE MEDICAL GROUP

Recommendation No. III concerns relationships to other groups:

"To fulfill its purposes, public health nursing can in no sense be conducted as an isolated activity. It cannot stand alone, and the measure of its ultimate effectiveness might well be evaluated in terms of its relationship to allied individuals and groups where mutual interdependence is or should be unavoidable."

The most important of these relationships exist with the medical profession, other social and health agencies, councils or federations for group planning, and lay groups, including those offering volunteer service.

This recommendation includes several sub-divisions. The first of these reads as follows:

1. It would seem desirable that the local medical society be informed of the nursing procedures of any public health nursing service by whatever agency administered, and that these in general be acceptable to the local medical profession.

Formal working relations should be established by two devices—the medical

advisory committee and standing orders approved by them or by the local organized medical group. Because official groups administering public health nursing do not employ these two devices and because they usually conduct only an instructive service, their relationship to the medical profession is not as well established or as satisfactory as that of the non-official agencies carrying a bedside service. This fact is readily understood. Objection to free clinics is almost universal. This problem has always been present to some extent but is much more serious now than ever before.

MEDICAL ADVISORY COMMITTEES

The need for this recommendation was revealed by the facts that only half of the non-official public health nursing agencies have medical advisory committees; that all of these committees meet irregularly; that no definite working relationship exists in any of the health departments or boards of education studied with local organized medical groups; and the relationships with private practitioners vary from the friendly to the antagonistic. While it is true that official agencies usually employ members of the medical profession to direct their activities or advise them in the performance of their duties, the absence of any formal relationship with the local groups is partially responsible for the lack of understanding of the objectives of public health nursing exhibited by the medical profession. In non-official agencies we have been aware of this lack but it is my personal belief that we have given it far too little attention and that in any misunderstanding between public health groups and the medical profession, we are somewhat responsible because of our failure to make known our objectives and to seek advice for our services as we developed our programs. The fact that our objectives are by and large the same, shows that failure to be seeing eye to eye must be due to lack of understanding. Sounder relationships could have and still may improve what tends to become an unfortunate situation. We have a real job to perform in this direction.

The second sub-division reads:

"The committee recommends the use of the social service exchange as an essential in the administration of an economical and efficient public health nursing service, if the service is to be integrated with other community health and welfare activities."

COMMUNITY COUNCILS

And the third is:

"The committee recommends that all agencies administering a public health nursing service be represented in community councils or the equivalent as a step toward a comprehensive social and health program for the community. Consideration might well be given in any locality to the development of uniform standards as to qualification of personnel and personnel policies, joint staff education, sharing of special consultants or supervisors, as well as to an understood division of responsibility as to program and definite methods for strengthening relationships and a technique of procedure in handling of individual cases in which other agencies are interested."

Again, official agencies are worse offenders than non-official in this arraignment of weaknesses and departures from good sound procedure that we are forced to face. Friendly relationships with other similar agencies is universal, while actual working agreements which lead to real understanding of each other's programs and proper division of work are almost totally lacking. In those agencies where the use of the social service exchange is becoming an indispensable help, it is hard to realize that this procedure is as yet an unusual resource in many non-official agencies and in most official ones.

In the communities surveyed about one-third of the boards of education, one-half of the health departments, and nearly all of the public health nursing agencies belong to a council of social agencies when one exists. The larger percentage of participation by private agencies can be attributed in part to the fact that they are member agencies of community chests, with one exception. This disturbing picture of casual and haphazard relationships between public health nursing agencies and other health and social groups in the community further substantiates the accusation I made at the beginning in regard to our resistance toward combining agencies under one or at most two administrations. Everything points

toward the fact that we work largely in isolated groups with little effective progress toward formal relationships. The costliness of duplication of effort and time has not troubled us much.

VOLUNTEER SERVICE

The last division of this recommendation concerns many of us in a dual capacity—as board members and as volunteers. It reads:

"The Committee recognizes that any carefully developed plan of public education through groups or through the participation of individuals in the work, takes time and energy. It feels that this would be time well spent and a legitimate part of the agency's program as it may mean the extension of the service through the support of public opinion as well as through practical assistance given."

It is true, I think, that most board members realize the value of maintaining good working relationships with local lay groups and that much hard work has been done in an effort to secure volunteer assistance and medical and material relief. Not so much thought has been given to the other aspect of the problem, however—that of giving a large group of citizens direct contact with the work and in this way spreading information and securing informed public opinion. The practical assistance rendered by volunteers who are largely drawn from these lay groups is becoming a very essential part of our programs, but in the long run the constant and accurate interpretation of the program to the community, made possible through proper training and use of the volunteer, will be of more lasting value. In a small number of agencies the potential value of the volunteer is recognized and plans are carefully made and carried out for making the volunteer thoroughly acquainted with the organization and administration of the service and the various phases of the nursing program, so that she can assist intelligently in the work itself and through her growing knowledge and increasing enthusiasm interest the outside community. In all too many agencies, however, placing the volunteer in routine work is grudgingly done and no thought is given to training her for future participation in board and committee work

or informing her so that she may help in formulating favorable public opinion. Here is another fertile field awaiting development.

STAFF PREPARATION AND PERSONNEL POLICIES

Again the Survey shows us that due to insufficient preparation for public health nursing work, the burden of preparing our staffs for their jobs rests largely on the agencies employing them. The fourth recommendation with which we are concerned reads:

"One of the major recommendations is that all public health nursing agencies provide for and improve their facilities for stimulating educational supervision and for a continuous staff educational program since it is evident that such provision must at present be looked upon as the chief source of professional education for the field of public health nursing in the United States."

This challenges us directly since it calls for procedure that is both time consuming and expensive. On the other hand, establishment of such a program assures the community of a service of better quality and higher standards. To give this is one of our avowed objectives, and we should be consistent by providing the budget allowance and the encouragement to the nursing staff for continuous education. Those of us who are interested in nursing education through membership on hospital boards and training school committees have a rare opportunity to encourage and even demand "the incorporation of a fundamental theory and experience which are essential as a basis upon which to build further public health nursing preparation and practice" into schools of nursing. It behooves us to recognize the value of these two means of equipping the nurses for the responsible tasks they undertake and which we sponsor. Sometimes the staff finds an unresponsive board when it endeavors to improve its own equipment—but boards have also been known to find an unresponsive staff when it recognized this obstacle to organizing an effective service. The irrefutable facts revealed by the Survey should stimulate both boards and staffs to action on this matter.

HEALTH OF THE STAFF

The fifth and last recommendation with which we are concerned primarily relates to the health of staff. Most of us are vitally interested in and truly concerned about maintaining the health of the nurses at a high level. Yet we often fail in this and the reasons are not difficult to find. But they increase our expenses and are sometimes inconvenient to carry out. The recommendation reads:

"It is strongly recommended that agencies employing public health nurses gain knowledge of the health of the nurse before appointment to the staff and make some provision for continuous health supervision after appointment."

In other words, this means requirement of health examination as a basis for appointment, regularly spaced health examinations subsequent to appointment, preventive sick leaves after periods of stress and strain, adequate sick leaves, and yearly vacations of adequate length. In spite of the fact that public health nursing agencies have as two of their objectives disease prevention and health promotion, only one-half of the agencies surveyed require health examination before appointment; only one-third require them after appointment; and only five per cent make

any allowance for preventive sick leave. These facts seem to indicate that we do not practice what we preach. My feeling is that this is one of the easiest situations to remedy and is due to a great extent to an unawareness of the proper steps to take to right it. Realizing the consistency of this procedure with the service we sponsor we can surely make short work of this obstacle to our efficiency.

There are several more recommendations of absorbing interest concerning the nursing program, performance of work, distribution of services, records and statistics, etc., all of which we discuss regularly in our board and committee work. We need to read them through to the finish, but for purposes of discussion these five that have been presented are of first importance to us, being those for which we are directly responsible. We must be impressed with the courage displayed in attempting this study when it was fairly obvious that the findings would be somewhat depressing. Now that it is made, everyone should be relieved to have facts rather than surmises to work upon and all seasoned board members should get a thrill when they learn that there is no danger of their work growing stale for want of new fields to conquer.



NATIONAL LEAGUE OF NURSING EDUCATION

The officers and Board of Directors of the National League of Nursing Education for 1934-1936 are as follows:

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Another Milestone in Industrial Nursing*

Mental Hygiene

By HEIDE HENRIKSEN, R.N.

Supervisor of Home Visitors, Twin City Lines, Minneapolis Street Railway Company, Minnesota

MRS. HODGSON, in her book, "Public Health Nursing in Industry,"** defines industrial nursing as "the application of nursing skills and procedures as applied to the sick and injured worker, and the sharing of information on the fundamental principles of healthful living as applied to the worker in his daily environment."

To us who are interpreting this definition in the needs of our particular industry, the problems of mental health are not new. We have had to learn to give recognition to the attitude of the individual worker, to his personality make-up and his reaction to his work environment. We have had to apply sound psychological principles in our health teaching to affect changes in habit or to adjust difficult situations. We are somewhat like the man who went into a restaurant and ordered "Pork Chops Florentine." When he was served he exclaimed, "Is this what they call pork chops and spinach!" We called the application of psychological principles "common sense."

Our task has been complicated by the period of economic stress through which we have just passed. The old social order has changed and the familiar guide posts are gone. The hours of work have been shortened and the tempo accelerated. In street railway transportation, with which I am familiar through my work, there has been a shift from the two-men cars to the one-man operated car. The job has become more complex. Habits of years have had to be changed to accommodate to new demands under time pressure.

To the former disabilities that brought the patient to the medical department, we have to add his reaction

to changes in work conditions, to reduced income, to uncertainty of employment, his reaction to an insecurity against which ordinary aggressiveness has been powerless. So dominant has been this influence that I reviewed our reports for the last five years to see if, perchance, the problem might manifest itself in tangible form.

Before referring to this study, I want to give you a brief background of our organization. The Twin City Lines is the street railway system of Minneapolis and St. Paul. The Health Department of the company is organized under a General Director who is also Social Service Director. There is a Medical Director, an Associate Medical Director, and "station physicians" who spend one hour daily at each of the six stations from which the men work. There are three nurses who work under the direction of the General Director and in close coöperation with the Medical Director and other physicians. The nurses are at the executive office building for the first hour of the morning and at other times by appointment. The remainder of the day is spent in home visiting and other services in behalf of the employees and their families.

The health service is administered through an Employees' Mutual Benefit Association, which, in a general way, provides complete diagnosis and medical care for the employee at the medical office. It provides payment for surgery and choice of surgeons. It takes care of \$50 of the hospital bill, X-rays, special appliances, and dental extractions and X-rays. There are sick benefits for a maximum of fifty-two weeks for one disability and death benefits. It provides payment for three-fourths of

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the cost of surgery for a wife or minor child.

MAJOR HEALTH PROBLEMS IN LAST FIVE YEARS

Membership in the benefit association for the five years was as follows: 1929, 2,841; 1930, 3,058; 1931, 2,685; 1932, 2,478; 1933, 2,414. This reduction in membership follows a corresponding reduction of force due to the dead line being reached in use of street cars as a means of transportation.

In reviewing our records, I selected paid claims for sick benefits as a basis of comparison, for the reason that the diagnosis on such claims had been accurately established and the amount of money represented that actually paid for a given disability. The figures are valid only as they refer to our own employees and they are significant merely as an indication of trends.

During the five-year period of 1929-1933 inclusive, sick benefits were paid on one hundred and fifty-eight diagnoses of illness or injuries. Many of these diseases occurred only occasionally and from the standpoint of incidence as well as cost in sick benefits, constitute a negligible health problem. For the purpose of this discussion, I shall confine the reports to those disabilities that constitute major health problems or are especially significant because of mental health implications. Our Medical Director was kind enough to review these reports and I shall include his comments in my interpretation.

Most obvious is the sharp rise in heart disease.* The nature of this disability is one that requires long periods of rest and consequently sick benefits are paid for corresponding periods of time. The incidence is keeping pace with the age group. In 1933, there were eight hundred and eighty-eight men between forty and fifty, seven hundred and five between fifty and sixty, and two hundred and forty between sixty and seventy years of age. In hypertension, again the age group and reaction to stress are significant elements.

*Limitation of space and cost prohibit the use of the five graphs that accompanied this paper, but anyone wishing to see them may borrow them from PUBLIC HEALTH NURSING, 50 West 50th Street, New York, N. Y.

The respiratory disease group includes la grippe, pneumonias, bronchitis, and acute pleurisy. The peak of the five-year period came in 1932. That year the payroll carried a very much larger number of men than were actually needed for work. There was not the incentive of waiting work nor any particular urge on the part of the management to bring them back promptly.

Tuberculosis showed a constant downward trend until 1933. It is too soon to say whether that is a jog in the curve or the beginning of an upward climb. One point not demonstrable on the tuberculosis curve is the increase in incidence in the younger age group. Interesting in this connection is the fact that a group of bus company employees were admitted to the association in 1933. They had not had physical examination on employment, so a very careful examination was given them on application for membership in the benefit association. This check revealed active tuberculosis in individuals who either did not know they had the disease or else were not facing the fact that it existed.

The duodenal ulcer curve is affected by depression worries and reaction toward work and this is one of the factors that determines whether the patient may be treated as ambulatory and do light work, or whether he has to be a bed patient. In cholecystitis the majority of employees belong to the age group where its incidence naturally is high. Appendicitis definitely follows the curve of acute respiratory infections. The incidence is highest during the peak of la grippe in winter and the so-called "stomach flu" in summer.

General and functional diagnoses include both functional and organic lesions of the brain and cord. They are second in rank in amount of money paid in sick benefits for this five-year period: a little higher in 1930 than the previous year, a slight peak in 1931, down in 1932, and back to the original level in 1933. Our Medical Director interpreted this curve from the angle of therapeutics

as well as incidence of claims. As a matter of principle, claims are not paid for melancholia or depression or any functional disorder unless the patient is actually committed to an institution for the care of mental diseases. Some concurrent disability is found, a hernia, varicose veins, gastritis, anemia—any concrete, curable diagnosis will do, and the patient is treated for his mental condition without external emphasis being placed on it. Truly dramatic are the simultaneous recoveries! The fractures and lacerations were accidents off duty—one can only conclude that it has been of little avail to say "Be careful today."

To complete the picture, I want to give you these figures: They are the average days of illness per case and the average cost per case for the same five-year period—eleven days in 1929, fourteen days in 1933; \$20.06 in 1929, \$25.30 in 1933. (Incidentally, the average number of days per illness before the social service and medical departments were established was over twenty.)

Our composite picture shows a sharp rise in degenerative diseases, a comparative level in the gastro-intestinal group; tuberculosis rising a little the last year; acute respiratory diseases dropping slightly, but always expensive to industry; nervous and mental diseases rather an even curve but from the standpoint of mental health, this very significant factor—a definite increase in the average number of days per illness and a definite increase in the average cost per case. Last year, the patient did not "snap out" of his illness with the same degree of decisiveness. Therein, it seems to me lies the most tangible expression of his reaction to elements of depression and insecurity.

FACTORS PROMOTING MENTAL HEALTH

In enumerating factors for promoting mental health in an industrial health program, I shall not confine myself to the nurse's part alone because no program is effective unless it is an integration of effort on the part of the management, the social service, the medical and nursing services. Nor shall I

attempt to arrange the component parts in order of their importance. It is the correlation of activities through coöperation that brings results.

With this in mind, I give you the following as being concrete and essential elements in an industrial mental health program:

1. Payments of sick benefits during illness. The knowledge that income will not cease does as much as any one thing I know of for peace of mind during illness.
2. Certainty of employment on recovery. Who can estimate what that has meant during these years when jobs have been so hard to get!
3. Social Service Department where help and advice is readily available. Of paramount importance is the integrity of this department.

In our organization it has existed for over twenty-two years and has the tradition of unbiased helpfulness. It is the first thought of the men when confronted with difficult or unusual problems; they know the advice they get is not colored by the hope of personal gain; they respect the maturity of judgment that years of experience with their particular problems has brought. In a mental health program, the importance cannot be overstated of having a department where the employees can be assured of a sympathetic and understanding counselor; one who can interpret their needs to the management if necessary but whose primary interest is in them as individuals.

4. Medical service. Like the Social Service Department, the integrity of the medical department is its outstanding attribute.

Our Medical Director also has had over twenty years of service in this organization and the attitude of our employees is expressed in the remark of a veteran employee who said to me, "Next to God, I depend on Dr. Turnacliff." The services of the physicians are easily accessible and are freely used.

5. Nursing service. The nurses are available for problems of illness of members of the family as well as the employees themselves and again years of association have formed bonds of sympathy and understanding so that the majority of the calls come from the patients directly and there is no hesitancy in seeking the services of the nurses.

6. Recreation rooms. At each station there are rooms with pool and billiard tables, card tables, chess and checker boards, a radio, a

library of books and current magazines and a refreshment counter. These rooms are also used for station parties.

7. Rest rooms. These have cots where the men may rest.

8. Shower baths and barber shops.

9. Dining rooms in the shops where one hot dish and beverage supplement the lunch brought by the employees.

10. "Sick bonus." These are hours of employment suited to the strength of the convalescent patient, and represent as fine an example as I know of, of coöperation between the management and the medical department. As it is used by the Medical Director, it has become a most valuable therapeutic measure in promoting complete recovery.

11. Retirement pension.

12. Group insurance with permanent disability clause.

WHAT THE INDUSTRIAL NURSE MUST KNOW

The industrial nurse does not have to concern herself with the diagnosis of mental health problems but she should be alert for significant symptoms. She should know the principles of mental hygiene and their practical application. It is not enough to know that the three common ways of meeting a conflict are repression, sublimation, and aggression. One must evaluate them in reference to specific situations and employ them toward desired results. Repression is not incompatible with mental health to a certain degree but it is difficult to control. Sublimation is difficult to achieve but is valuable in specific instances. Aggressiveness is effective and practical. We may well keep in mind that illustration of Dr. Dewey, "We do not run because we are afraid; we are afraid because we run."

I recall a patient who had a stiff knee following an injury. We tried for weeks to get him to exercise but he persisted in using a crutch and walking with his knee stiff. I made repeated visits to his home and he submitted to passive exercise. I took him to the Curative Work Shop of the Visiting Nurse Association, but still I had to help him back and forth to the doctor because he could not bend his knee to step up on the street car. One day we went for an X-ray to an office on the nineteenth floor of the Medical Arts Building. As we went to the elevator, the red exit sign was an inspiration and I said in a very firm voice, "We will walk down

this flight of stairs to the next floor." I took away the crutch and by the time we reached the floor below, he was placing one foot ahead of the other as he went down. Still very firmly I said, "We will walk down one more flight and then you may take the elevator." The patient himself suggested walking the next flight and then the comedy began. At each landing, I urged the elevator but the patient persisted in walking the stairs. By the time I had accompanied him down nineteen flights of stairs, I was walking as if I had a cord lesion and he was bending his knee with all the grace of a dancing master.

In frank mental cases, it is the policy of our Medical Director to care for the patient at home whenever conditions permit. The patient cannot be treated as an individual with an aberration from a norm that can be classified scientifically and rectified. He must be considered a member of a work group to which he is to be returned in a state of maximum efficiency in as short a time as possible. It is very much easier for the patient to return to his foreman and fellow workmen if he has been confined to his home with a phlebitis than to return from the state hospital for the insane.

The nurse can help with practical suggestions for home care. We have a loan chest of sick room conveniences that add to the ease of caring for a patient at home and also to his comfort. The nurse can influence the family attitude and add to their understanding by well considered teaching. Friendly contact helps. Well selected, simple reading can be supplied. One cardinal principle in dealing with psychopathic patients is to keep a promise always and to the minutest detail. The confidence of the patient is half the cure.

There are the border-line mental conditions—the malcontent at work, the emotionally unstable, always complaining of a thousand subjective symptoms. There is the victim of the health urge, self-educated by subtle and seductive advertisements. He eats health foods and ruins his digestion by worrying over the vitamin content. He buys magic salts and radium water and wears potent

belts. The nurse listens—and apropos of listening, what more valuable device in mental health problems do we have than just wise listening? There is the relief to the patient in getting it out of his system into safe ears. Sometimes in the telling, a plan of action is formulated. The danger lies in permitting a patient to get the habit of telling his troubles merely to get non-constructive sympathy. Another danger lies in permitting this type of patient to encroach on time out of proportion to the significance of his trouble. The nurse must evaluate what she hears and refer to the medical department symptoms that are significant. The nurse can help with work adjustment for these people and properly considered information to the foreman is valuable in maintaining the individual at a level of efficiency that he may be retained on the job and remain self-supporting.

In any illness, one point seems to me worthy of special mention. When contacting the family and interpreting the care needed, a conscious effort should be directed toward counteracting that solicitude on the part of the family that keeps the patient a protracted invalid. Do not put the emphasis on the patient and his discomfort. Except in incurable diseases, explain his care and assume that he is going to get well promptly. Emphasize the need for better health habits. An illness does not seem so dramatic when one realizes that he probably precipitated it by faulty eating habits or silly indiscretions. Sometimes it is effective to sympathize—ever so discreetly—with the wife for the additional burden of illness, especially over those tremendous washings. Emphasize intelligent care and coöperation and minimize the dramatic situation of being ill.

The industrial nurse who does home visiting is in a particularly strategic position to observe extraneous factors that contribute to worry and retard recovery. Financial problems are referred to the Social Service Director as also are complicated problems of family adjustment. Sometimes simple suggestions on the part of the nurse afford a direct attack on worry situations. For

instance, we have used effectively the family budget plan recommended by the Family Welfare Association and the weekly menus planned by them. There are the special problems caused by too many extra people in the home. Children get married and return with their families because they cannot find work to support themselves. Divorced daughters and sons always seem to come home to live. Parents-in-law become dependents—and the man with the steady job carries the load. It is not strictly within the province of the nurse to solve these problems but when illness calls her into the house, there is no reason why she should not take constructive action, after first making sure there is no other community agency already helping them with their problems. For instance, a grocery order from the Department of Public Relief for the married son who cannot find work, the day nursery for the infant of the divorced daughter, or any of the community resources may be brought to the attention of the family to good advantage. In a recent case, an employee was suffering from a neuritis that grew persistently worse. His mother-in-law lived with them and they had two small children. The mother-in-law was gradually becoming helpless because of a serious heart lesion. She had to be lifted from the bed to a chair and her care was becoming so burdensome that my patient's wife was exhausted and irritable to the point where she almost needed medical attention too. Through the General Hospital the elderly woman was placed in a modest nursing home. The atmosphere of the home changed and the patient showed immediate improvement.

Coöperation with other social and health agencies is so fundamental in any industrial nursing program that I merely mention it in connection with the special program of mental health. The nurse should avail herself of the psychiatric clinics, behavior clinics and other community resources, and furthermore, she should keep herself informed of their accepted standards of treatment and teaching so there may be a uniformity in the community health program and

the individual is not confused by a disparity in health instructions.

The scope of this subject is so broad that obviously it is impossible to do more than touch the surface in a discussion like this. I began this paper with the title "Mental Hygiene—Another Milestone in Industrial Nursing." I am tempted to paraphrase the biblical precept: "Whosoever shall compel thee to go a mile with him, go with him twain," and change the title to "Mental Hygiene, the Other Mile." The first mile includes the well trained nurse, mindful of the fundamental principles of public health nursing, maintaining her work on a par with the best nursing service in the community so that there

is a coördination of service in the community health program. The other mile is an intelligent understanding of the mental health as well as the physical problems and the growing in professional stature to meet these situations that have ever been present but now are accentuated by the stress of the times.

About fifteen years ago, our Medical Director set the example when he gave the nurses this motto: "No services are of value, but only likeness. When I have attempted to join myself to others by services, it proved an intellectual trick—no more. They eat your services like apples, and leave you out. But love them, and they feel you and delight in you all the time."

WHERE TO FIND THE OTHER CONVENTION PAPERS

The *American Journal of Nursing* will carry in its June number:

A report of the opening session and "Highlights of the Biennial"
"The Changing Order and Nursing"—Annie W. Goodrich
"Legislation and the Future of Nursing"—Adda Eldredge

"The Changing Order and the Hospitals"—Nathaniel W. Faxon, appeared in the May *Journal*. The *Journal* and this magazine plan to publish Mrs. Roosevelt's paper in July.

For papers from the A.N.A. meetings and the League see the *American Journal of Nursing*. The only paper from the A.N.A. sessions published in this magazine appears on page 300.

We believe our readers will find "A Plan for Incorporating the Social Sciences in the Curriculum of the School of Nursing" by Ruth E. Lewis, and Miss Frost's discussion of this paper of interest (see July *Journal*). Also, "How Shall We Measure the Quality of Nursing?"—Lyda W. Anderson, R.N.; "The Need of Subsidiary Workers in Nursing Service"—Alden B. Mills; "Coördinating the Teaching of Sciences and Nursing Practice"—Sister M. Berenice Beck, R.N., in June.

Addresses from the N.O.P.H.N. and joint sessions planned for future publication in PUBLIC HEALTH NURSING are:

"How to Improve the Teaching Content of a Public Health Nursing Visit"—Leah Blaisdell.
"How to Improve the Teaching Ability of the Nurse"—Ruth Gilbert.
"Lay Advisory Committee for an Official Agency"—Mrs. George Carpenter, Jr.
"Changes in the Field of Education"—Bess Goodykoontz (September School Health Number).
"Budget Planning in the Official Agency"—Amelia Grant, and "In the Non-Official Agency"—Ruth Hubbard.
"The 'Survey of Public Health Nursing Administration and Practice' as it Relates to the School Nurse"—Hortense Hilbert (September School Health Number).
"Personnel Policies for Official Agencies"—Robert T. Lansdale.
"Community Responsibility for Health"—Eduard C. Lindeman.
"The Provisions Made by Industries for the Material and Medical Relief of Their Employees"—Me'da F. McDonald (July).
"Is the Public Health Nurse Behavior Conscious?"—Esther Loring Richards, M.D. (September School Health Number).
"The Need for a More Adequate Program of Maternal Care"—Frances C. Rothert, M.D.
"Improving the Content of the Visit from the Point of View of Teaching"—Ann Seeger.
"Lay Participation in a State Program"—Mrs. Arch Trawick.

A summary of the reports from state public health nursing organizations will appear in August. A list of board members attending the Convention will be published later.

How Can Public Health Nursing Services be Combined?*

By ALMA C. HAUPT, R.N.

Associate Director, National Organization for Public Health Nursing

DURING the past twenty years combinations of local public health nursing services have been taking place in this country and we may well ask, why? The reasons may be summed up as an attempt to reach our aim of optimum service to the individual, the family, and the community.

To be more specific, the outstanding successes of twenty combined services as reported by those in charge of them suggest four good reasons for this trend:

1. *A broader program* adjusted to community needs. For example, some agencies after combinations were effected, added communicable disease service, infant welfare clinics and bedside care, which had not been offered before the combination.

2. *Greater efficiency* involving economy of time and money, and the elimination of duplication.

3. *The development of the nurses* to fuller capacity, making use of all phases of their previous training and stimulating them to continued study to meet new demands. This is said to result in greater satisfaction to the nurses themselves and better handling of family health problems.

4. *Improved understanding* of public health nursing on the part of families, health departments, the medical profession and the whole community. As one nurse director expressed it, the combining of services "sold public health nursing to the community."

If our reasons for combining services are then a broader program, greater efficiency, fuller development of nurses, and improved community understanding, they would seem to fit into the new challenges of the social and economic order of the day. Professor C.-E. A. Winslow says public health nursing has taught two "lessons of profound importance":

"First of all, the development of public health nursing organization has been of great significance in indicating the possibilities of organization for common service by members of a professional group and suggests valuable lessons for other professions confronting similar problems.

"Secondly, we are indebted to the public health nursing organizations for the growing realization of the importance of generalized service, that is, the treating of the entire health of the entire family as a single social problem."

Professor Winslow's statement is an encouragement to those who have already combined services, and a challenge to others to consider this move.

Another challenge is made in the recommendation of the "Survey of Public Health Nursing"** "that all public health nursing services be carried on by as few agencies as possible." It suggests where feasible but two agencies, one public and one private, with experimental demonstrations of but one agency in selected places.

The challenge of all challenges, however, grows out of the economic depression. Combinations in all fields of endeavor are "in the air." "New Alignments"*** are occurring in the social work field. Changing phases in support are rapid. The public has a new interest in welfare and health work. Boards of directors see new values and are more willing to experiment with new methods. Agencies with a common cause or related causes are drawn together more closely. Group thinking and group action are evolving under the leadership of community-wide councils for social work and health. Any effort toward combination is dependent

*Presented at the General Session, National Organization for Public Health Nursing, Biennial Convention, Washington, D. C., April 26, 1934.

***Survey of Public Health Nursing*, by the N.O.P.H.N. The Commonwealth Fund, 41 East 57th Street, New York, N. Y. \$2.00.

***See *New Alignments Between Public and Private Agencies* by Linton B. Swift, Family Welfare Association of America.

on planning and group action as provided in some form of council.

HOW TO COMBINE

If, then, there are four good reasons for combining public health nursing services, and if these fit in with the challenges of our times, we are not content with merely wishing to combine, but we want to know how our wishes can be translated into fulfillment. The experience of twenty agencies that have combined was collected through a questionnaire by the N.O.P.H.N. in October, 1933, and the replies form the basis of this discussion. These agencies were all located in cities in fifteen widely scattered states throughout the country.

This review covers in all the experience of fifty-seven organizations which ultimately combined their nursing services into twenty. In the original combinations there were forty-nine organizations, later ten more were added, and two withdrew. The twenty combined services as they exist today represent three health departments and seventeen private agencies.

ORGANIZATIONS WHICH PARTICIPATED IN THE ORIGINAL COMBINATIONS

PUBLIC

Health Departments.....	12
Boards of Education.....	2
	—14
<hr/>	
PRIVATE	
Visiting Nurse Associations.....	14
Tuberculosis Associations.....	2
American Red Cross Chapters.....	3
Metropolitan Life Insurance Services.....	3
Infant Welfare Societies.....	4
Other	9
	—35
Total	49

The extent to which these combinations have embraced existing agencies is illustrated by these figures:

NUMBER OF ORGANIZATIONS OUTSIDE OF COMBINATION

None in 2 cities.	
One in 11 cities:	
Board of Education.....	5
Health Department.....	1
Metropolitan Services.....	2
Tuberculosis Association.....	3
Two in 5 cities:	
Health Department and Board of Education	2
Health Department and Tuberculosis Association	1

Board of Education and Tuberculosis Association	1
Health Department and Tuberculosis Association	1
Three or more in 2 cities.	

Naturally no two combinations are identical but in general they fall into three types:

1. Mergers:
 - A. Two or more private agencies.
 - B. The nursing services of both public and private agencies.
2. Transfers of service from one agency to another:
 - A. From private agency to public agency.
 - B. From public agency to private with public subsidy.
3. Combination of services within an agency.

In those instances where a combination of services resulted in a merger of agencies, a new board was formed on which were representatives of the agencies which had combined. In some cities where mergers were formed several years ago, the need for board representation of former agencies is no longer felt. In other cities, there is still board representation from all organizations contributing to the nursing service.

Seven of the combinations resulted in the appointment of a new nurse director from outside the community, the reasons given being as:

- No local nurse qualified
- Need for an objective viewpoint
- Vacancies in agencies combining

The size of staff in the present combined services ranges from 5 to 119 nurses. All with more than 10 nurses have supervisors. The average number of staff nurses to 1 supervisor is 8.37, indicating that combinations bring nurses a good standard of supervision.

SUPPORT OF COMBINED SERVICES

The annual income of these combinations ranges from \$11,704 to \$207,871. Only two of the agencies receive their whole income from tax funds. Some receive tax funds and private contributions; others derive their income from tax funds, contributions and earnings. The private agencies carrying on combinations receive their appropriations from other organizations in two ways: In some, lump sum payments are made on a monthly, quarterly, or yearly basis.

This makes possible a true pooling of funds which they consider satisfactory. In others, the payments are made "in kind," in the form of salaries to certain members of the staff, office space, transportation, and supplies. One agency has a definite contract with the city, renewable every two years.

SERVICES TO THE COMMUNITY

We come now to the *raison d'être* of this whole question of combinations—namely, what services are offered to the community. You are asking, of course, what specific combinations of services are made. Twelve of the twenty agencies combine all of the following: bedside, maternity, infant and preschool, school, communicable disease and tuberculosis services.* Five other agencies combine all of the above services except school nursing. The three remaining agencies make variations of less extent. It is indeed striking to find that, with the exception of school nursing, practically all the major types of public health nursing service are combined in seventeen of the agencies and that twelve of them include school nursing. All twenty agencies provide antepartum, infant, and preschool service, and eighteen give bedside care including communicable disease and tuberculosis nursing.

We find that sixteen agencies completely generalize their home visiting so that only one nurse visits the family and gives every type of service included in the agency's program. Of the four remaining agencies, all report the majority of their services provided on a generalized basis. One of the agencies uses the specialized approach in tuberculosis and venereal disease work only; another has a specialized prenatal service and two have specialized school nursing services.

Clinic services are carried on by fifteen of these twenty agencies, and here again it is interesting to note what types are included most frequently.

TYPES OF CLINICS AND CONFERENCES

Prenatal	10
Infant	15

Preschool	12
Tuberculosis	8
Venereal Disease	4
Other	7

(Dental, Nutrition, Orthopedic, Medical)

Clinics are conducted with nursing service furnished, in the majority of instances, by the nurses who do home visiting on the generalized basis. This brings up one of the most important considerations in this whole question of combinations. The clinic gives an opportunity for the individual patient or family to have contact with specialists in medicine. Furthermore, it is of tremendous educational value to the nurse in keeping her up-to-date in the technical aspects of the various branches of medicine. The generalized nurse who serves the special clinic has the dual opportunity and responsibility when visiting the home of seeing the total family health situation and of bringing to the family the teaching of the specialist in such a way that it fits into the whole family health picture.

DIFFICULTIES IN THE WAY OF COMBINATIONS

Let us return, at this point, to the four reasons for combinations given in the beginning of this paper stated by those in charge of the combinations as the outstanding reasons for success: a broader program, greater efficiency, fuller development of the nurses, and improved community understanding. We now want to look at the other side of the picture, for these successes have not been won without difficulties. However, the fact that these combinations have in every instance survived and that subsequent to their beginnings ten additions were made to them and only two withdrawals occurred would seem to indicate that the initial difficulties were overcome. Limitations of budget, small size of staff, and low salaries which some of the directors mentioned as present difficulties are, alas, not characteristic alone of combined services. What agency does not have them? Two directors report political control as a continuous problem; one feels the need of a written agreement with the health department;

*Of these, four offer delivery service as part of maternity care.

and one is concerned as to how to maintain the interest of board members of previously existing agencies in the new service.

Of special significance are those difficulties which arose at the time the combinations were formed. Lack of understanding on the part of the medical profession was reported in one instance; opposition of the staff to the change, in another; skepticism on the part of board members, in a third. That there were not more such expressions of doubt is surprising, and that time has removed many of them is encouraging.

Although not specifically reported in the questionnaire, it is known to have been the feeling of some boards that their ownership of a building, the holding of endowments or other "vested interests" made it difficult to take part in a combination. Legal advice has cleared the air in such situations and has shown that it is no more difficult to merge nursing agencies than it is to merge banks and other industrial organizations. When a real merger is under consideration, it is usually more acceptable to all concerned if an entirely new organization with a new name is formed to which each of the merging agencies may contribute the best which it has to offer. As one board member said, "It is like having my daughter married to the right man."

The final question of our inquiry was "What steps would you have taken differently?" It is rather amazing to find that eleven out of the twenty replied "None," one adding "Because it works!" Some of the suggested changes are interesting and may be helpful to others. One reply recommends preparing the staff technically and psychologically for the change. Another feels they took too long for preparation and might have generalized sooner. Retaining the active interest of coöperating groups is urged by one agency which apparently lost this interest. Others mentioned "lump sum" appropriations from the city rather than appropriations "in kind," signed contracts, more supervision, more nurses, further extension of program, development of adequate support.

IMPLICATIONS FOR THE FUTURE

The reason for this review of twenty combinations of public health nursing services is to see what implications we may draw for the perplexing future that lies before all forms of social and health work. As Linton Swift remarks in "New Alignments": "It is a mistake to assume . . . that business and industrial recovery will soon enable us to return to the more or less even tenor of our old ways of doing things. The old days are gone; we face a new future alignment."

If, in public health nursing, as our "Survey" shows, we have thinned our services by dividing them up into too many parts and too many agencies in a given community, is not our future new alignment along the lines of combination of services and merging of agencies so that there may be possibly but two agencies offering public health nursing in each community—one the public and one the private? In some communities, particularly the smaller ones, experience is showing that one generalized service is sufficient.

How then can local interest be awakened in the problem of combinations? One possibility (which is also a necessity) is constant interpretation to the local health officials and to members of boards of directors of the basic philosophy of public health nursing as a family health service. If the public understands the advantages of generalized nursing service in the home, the desire to provide that service will offset resistance to the modification of this or that established agency.

Another means of awakening local interest is by a community-wide survey of public health nursing. A survey is first and foremost an educational device, using analyses of community need and the quantity and quality of service available to meet that need as concrete examples of the principles of public health nursing. When such surveys are made by an "outsider" an objective viewpoint is expected of the surveyor and often local board and staff members find it possible to submerge their "agency consciousness" in plans for

meeting newly recognized needs for community-wide service.

Equally pertinent, if not more essential to combinations, are the thinking and planning of representatives of all groups interested in public health nursing, made possible through a health council, a nursing council, or some subdivision of the council of social agencies. No combination can or should be "put over." Public opinion as represented in a council group is essential to a smooth and successful change of organization. Where a council does not exist, a committee representative of all groups, public and private, concerned with public health nursing may be formed

as an initial step toward future coordination of services.

Change is always trying—one nurse director wrote of her combination of service that the period of change was "painful." Combining services calls for real leadership and real statesmanship. We believe that among our board members, our health officials, and our nurses we do have that type of leadership and statesmanship that can face facts, plan action and carry through in the face of difficulties if—as these twenty agencies seem to feel—a better, broader and more economical public health nursing service is offered to the individual, the family and the community.



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